

NURTURING THE FUTURE:
EXPLORING MATERNAL HEALTH KNOWLEDGE, ATTITUDES AND
BEHAVIORS AMONG MI'KMAW WOMEN

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DEDICATION

I dedicate this dissertation to my mother Dr. Marie Battiste and my father Dr. James Youngblood (Sa'ke'j) Henderson for everything they have given me to bring me to this point. I would also like to dedicate this thesis to all the Mi'kmaw babies who are yet to be born and to their mothers and their families.

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GLOSSARY OF WORDS:

Aboriginal- Aboriginal Peoples is a collective name for all of the original peoples of Canada and their descendants. The *Constitution Act* of 1982 specifies that the Aboriginal Peoples in Canada consist of three groups – Indians, Inuit and Métis.

Colonialism - Colonialism is a term to describe the control over and governing influence of nation/ country/ territory over the people they have colonized.

Colonization- Colonization can be defined as some form of invasion, dispossession, subjugation of a peoples, and the dispossession of vast amounts of lands from the original inhabitants².

Elder- Elder is used to describe someone who has knowledge and understanding of the traditional ways of his or other people, both the physical culture of the people and their spiritual tradition.

First Nations: Many people prefer to be called First Nations or First Nations People instead of Indians. The term is not a synonym for Aboriginal Peoples because it doesn't include Inuit or Métis. The term First Nations generally applies to both Status and Non-Status Indians.

Indian: Indian Peoples are one of three peoples recognized as Aboriginal in the Constitution Act of 1982 along with Inuit and Métis. In addition, three categories apply to Indians in Canada: Status Indians, Non-Status Indians and Treaty Indians. The term Indian is considered outdated by many people, and there is much debate over whether to continue using this term.

Indigenous Knowledge: refers to the knowledge base of Indigenous peoples that may have been passed down through generations through many venues such as teachings, oral histories, stories, folklore, rituals and ceremonies. These knowledge systems can be local to a specific area, and can include long standing traditions.

Indigenous- Indigenous means native to the area. In this sense, Aboriginal Peoples are Indigenous to North America. The meaning is similar to Aboriginal Peoples, Native Peoples or First Peoples. The term is gaining acceptance, particularly among some Aboriginal scholars to recognize the place of Aboriginal Peoples in Canada's late-colonial era and implies land tenure. The term is also used by the United Nations in its working groups and in its Decade of the World's Indigenous People.

Interconnectedness/Balance- In Aboriginal worldview, interconnectedness is a balance of human entities (physical, mental, emotional and spiritual factors), environment, and relationships (familial, societal).

Medicine Wheel: a symbolic metaphor represented by a circle and four quadrants each representing key themes of mental/cognitive, physical, emotional, and spiritual.

Mi'kmaq: translated as drawing from "Ni'kmaq" meaning my family, Mi'kmaq refers to the People inhabiting as original peoples of the eastern Atlantic coast.

Mi'kmaw: An adjective always comes before a noun, describing a quality belonging to the Mi'kmaq.

Native- A general term to describe Aboriginals, First Nations peoples, Métis, Inuit, Innu or any other indigenous people(s).

Oral teachings- This is an ancient but valid form of Aboriginal teaching using storytelling and other oral forms of education.

CHAPTER ONE

INTRODUCTION AND LOCATION

Personal Location

The focus of this research on maternal health care among Mi'kmaw women emerged from my background in women and gender studies and community health and epidemiology studies at the University of Saskatchewan, from my maternal health care research, and my growing apprehension for the future of Mi'kmaw women and girls' maternal health given the high risks reported in the literature. I am a Mi'kmaw woman, a member of the Potlotek First Nation and a resident of the Eskasoni First Nation in Nova Scotia, Canada. My early childhood and elementary school years was spent in these two First Nations communities after the age of two. My mother was working in Potlotek and later in Eskasoni School, where I was raised, especially among a group of Mi'kmaw speaking women who became my core maternal mothers. Being raised in the Mi'kmaw language, I have a growing although limited speaking language ability in Mi'kmaq, the first language of the communities in Cape Breton. The language continues to change over the years with more and more young people speaking English although almost all elders today have a fairly good speaking ability in English.

From a young age, I was part of women's groups who would talk about their daily lives and while it was frowned upon that young children listen in on these conversations, I did listen in on their daily dialogue and became aware of the women who were pregnant or of their own pregnancies, as this was a frequent topic among the women. As I grew older, I became ever more aware of the increasing number of younger girls who were becoming mothers. Maternal health as an issue of concern first occurred to me when a friend of mine became pregnant at the age of thirteen. I was shocked that this had happened to someone so young. As she came closer to her due date, I could hear the rumblings of the elders in the community speaking of what a shame it was, and how she had ruined her life. I felt the opposite; I loved children and was happy to see a new addition come to our community. Sadly, her infant died shortly after birth. Not long after that, I had another encounter with another peer's early teen pregnancy. This neighbor and friend became pregnant at the age of fourteen years. Fearing to tell her parents, she

decided to keep the pregnancy a secret from everyone until the final months. It was only then that she finally received prenatal care. Her birthing experience was difficult and her child has had multiple medical problems over the years. I wondered how much of a difference early prenatal care could have made towards a better outcome for both mother and child. Since that time, I have had several friends give birth, many of whom have struggled through difficult pregnancies. Listening to their stories, I heard them speak of events and conversations that were blatant discriminatory or racist when they did seek prenatal care. As they relayed their encounters, I felt anguish over their poor treatment during such an important period in the health of mother and child. I also began to question the quality of the formal healthcare services that these friends were receiving, as they described their difficulties with accessing health care services, whether doctors or hospitals. I have seen them go hesitantly to health centers for prenatal examinations and follow-up care and realized that these young women were beginning their pregnancies laden in fear associated with teen motherhood. The stigma of being a young First Nations teen mother has not been an easy road for many from my experiences with friends who were teen mothers. This is curious to me since historically the women of my community had their first child during their teen years.

These experiences and my reflections of them have imprinted on me early in my life a passion for babies and childbirth, which continues to this day. My love of babies has become well known in the community and I have taken on the role of mother's helper during the first six weeks of many of our children's lives. I have come to learn much about the importance of healthy pregnancy for healthy children. My interest in gender and health framed my choices for undergraduate education in this area and as I moved into a graduate program it seemed only natural that I would take the opportunity to focus my thesis research on a systematic exploration of experiences of pregnancy and childbirth for the women of my community.

Problem Statement:

While tremendous diversity exists among Aboriginal peoples of Canada, many statistics given of them suggests a homogeneity that may not exist entirely. Aboriginal peoples are a group of peoples who have lived in many diverse areas and locations, from

the east coast to the great lakes to the prairies to the west coast and to the North across the tundraⁱ. Each group has unique and diverse characteristics; unique skills and knowledges, unique languages and cultures and many consider themselves different from even those within their own community. So statistics of Aboriginal peoples can be misleading although they are used to suggest issues among them that need to be resolved.

First Nationsⁱⁱ and Aboriginal peoples have held the unfortunate and undistinguished status of having the poorest health care outcomes of any ethnic group in Canada in almost every sector of health^{3, 4}. First Nations women have been identified as being especially vulnerable and are commonly viewed as being at “high risk” during pregnancy because they experience higher rates of gestational diabetes^{5, 6}, infant mortality^{7, 8} and infants with abnormal birth weights^{9, 10} than Canadian women. High risk has come with negative cognition towards one’s health, and often puts First Nations women in a separate category from Canadian women. Despite the evidence of “high risk” pregnancies, First Nations women are less likely to seek early prenatal care in comparison to their Canadian counterparts. This issue is not fully understood, but at present it is attributed partially to the stigmatization of First Nations women¹¹, stemming from deep roots in the historic cultural and social fabric of Canada embedded in prejudice and racism that has emerged from the privileging of colonial societies and the diminishment of Aboriginal peoples. While research among Aboriginal peoples is emerging with more balanced perspectives, the research has by and large been framed from a deficit perspective where First Nations women have been labeled “at risk” in health care or characterized as having “high risk sexual behavior”¹². This labeling of First Nations women based on statistical or qualitative studies locates blame at the level of the individual and likely contributes to a health care environment that is seemingly hostile or unwelcoming for First Nations women¹³.

As a First Nations woman growing up in my home community, I have been privileged to receive Mi’kmaw traditional knowledge on the topic of women’s health as

ⁱ Aboriginal Peoples is a collective name for all of the original peoples of Canada and their descendants. The *Constitution Act* of 1982 specifies that the Aboriginal Peoples in Canada consist of three groups – Indians, Inuit and Métis.

ⁱⁱ First Nations generally applies to both Registered Status Indians and Non-Status Indians who live in Canada.

part of community daily dialogue. My elders have always pointed out to me their traditional beliefs about pregnancy, menstruation, and women's roles in the community as part of my socialization into my culture. In a western biomedical context, many of their traditional beliefs have been discredited as being myths, folklore and superstitions. I choose to see these beliefs as folk-knowledge held by Mi'kmaw peoples, holding a special social context and purpose. In the new context of changing regard for Indigenous knowledge in the sciences, sustainability and biodiversity, these knowledges need to be unpacked to unravel the important health care knowledge in them so they may be properly located beside biomedical knowledge and privileged in an improved model of maternal health care.

The problem as I see it, is therefore two-fold. First, we do not have a full understanding of the pregnancy and birth experiences of First Nations women from their perspectives and within their contexts. Second, we do not have a framework for understanding these experiences that reflect the bicultural traditional and western context in which they unfold. There is a great need to examine how First Nations women merge their cultural teachings with those maternal health teachings that come from western medical knowledge.

Research Objectives and Questions

This study contributes to the research on First Nations women's maternal health and the care received by bringing to the center the voices and experiences of the Mi'kmaw women from the two First Nations communities in Nova Scotia (Eskasoni and Potlotek), and examining their values, attitudes and decisions about their health care, especially when pregnant. The objectives are as follows:

1. To gather knowledge about the pregnancy, childbirth, and new mother experiences of Mi'kmaw women in Cape Breton, Nova Scotia so as to inform the development of more appropriate maternal health programs and services for these women.
2. To contribute a framework that incorporates the traditional and western-informed First Nation experiences of maternal health to the literature, filling an identified gap.

The objectives will be addressed through the following research questions:

1. What are the experiences of maternity and childbirth for Mi'kmaw women over the last fifty years (1960-2010)?
2. How is Mi'kmaw traditional knowledge about pregnancy and prenatal care learned among Mi'kmaq women and what significance does it have for health care among women in the First Nations communities of Cape Breton?
3. What are the complementarities and conflicts between Mi'kmaw knowledge and practice and western knowledge and practice and health experiences of maternity over the last fifty years? How do these knowledge systems interweaving together affect Mi'kmaw women's decision-making process during pregnancy and birth?
4. What are the implications for improving maternal health care that would reflect the values and beliefs about pregnancy and childbirth for Mi'kmaw women?

Significance of the Study

My hope for this research is that it will be able to influence change in the way pregnant women navigate traditional and western knowledge about health maternity and childbirth so that the experience unfolds in a positive environment with improved outcomes for mother and child. I hope that the gathering of Mi'kmaw narratives during pregnancy results in a greater understanding of the nature of and the function of Mi'kmaw women's traditional knowledge in their society. In doing this research, analyzing the data, and drawing conclusions, I also want to 'nurture the future' by identifying changes or making suggestions to create a more responsive and culturally appropriate maternal health care services that are needed to create better maternal health outcome for First Nations women. Finally, on a personal note, this research fulfills my desire to work within my own community on a topic very close to my heart: the future children of these communities.

Chapter Overview

The remaining four chapters of this thesis are organized as follows. Chapter Two includes a literature review covering some statistics on First Nations maternal health in

Canada, as well as some of the research that has been conducted in this area. As will become apparent, little research on First Nations maternal health has been conducted from the perspective of the women themselves. Chapter Two also introduces the theoretical framework for this study, an adapted medicine wheel that facilitates the inclusion of traditional and western influences on the maternal experiences of Mi'kmawⁱⁱⁱ women. Mi'kmaw women live a reality that requires them to negotiate these two worlds as a matter of course, so it is appropriate that a research framework capture this as well. Chapter Three introduces the research communities, describes the narrative approach to data collection, the analytical strategy, and ethical considerations and processes. The presentation of results in Chapter Four begins with a description of study participants, reintroduces the medicine wheel framework, presenting results according to their location on the wheel. Chapter Four looks at four life themes of the participants: becoming a woman, pregnancy, birthing, and motherhood. Within each life theme, the stories of the participants are categorized further into the medicine wheel quadrants, of physical, emotional, spiritual, and mental. Chapter Five's discussion and conclusions draw out the key findings and locate their significance relative to the existing literature and recommendations for program and policy around maternal health for the people of my community.

The appendices contain various ethics approvals required to undertake this research at the University of Saskatchewan and among the Mi'kmaw Ethics Watch, an overseeing body of Mi'kmaq who have been assigned the role of administering Mi'kmaw ethics. The appendices also include the informed consent forms for individual interviews and focus groups, the transcription release, the question guide and the recruitment poster used to promote the research.

ⁱⁱⁱ Mi'kmaq is the word for the people and is a noun. Mi'kmaw is the adjective form and always is positioned before the noun.

CHAPTER TWO

LITERATURE REVIEW

First Nations Women and Maternal Health

This chapter begins with an overview of the literature on First Nations maternal health in Canada, first considering what we know from survey and other data sets, and then what little research has focused on the maternal health experience of First Nations women. I conclude with the presentation of a conceptual framework based on the medicine wheel that guides my research and which has permitted a wide exploration of the maternal and childbirth experiences of Mi'kmaw women from my home community. This framework allows for a combined analysis of western- and traditional-informed aspects of the experience, and how women navigate their experiences in the sometimes contested, sometimes complementary, and often complex, processes of seeking the best possible care and advice for themselves and their developing child.

Maternal Health and Healthcare among First Nations Women in Canada

The First Nations population is growing rapidly and the need for improved prenatal health care will be increasingly felt in the next decade. The Royal Commission on Aboriginal Peoples (RCAP) reported in 1996 that one third of the Aboriginal population was under the age of fourteen¹⁴. Ten years later, in 2006, Statistics Canada data found similarly that 30% of the Aboriginal population was under the age of fourteen, showing a small decline of 3% in the younger Aboriginal population¹⁵. The youthful population surge among Aboriginal peoples is increasingly being seen as an important demographic in Canada as this population will be the future's childbearing populations. This youthful population demographic, combined with high fertility rates is linked to relatively high birth rates and predicts ongoing population growth.

In a recent count of the population of the Eskasoni reserve in Cape Breton, Nova Scotia, 56% of the population is under the age of twenty-five and the birth rate is growing¹⁶. Eskasoni First Nations reserve has an approximate population of 3600 permanent residents, making it the largest Mi'kmaw reserve in Atlantic Canada¹⁷ as well

as being the largest First Nations reserve east of Montreal¹⁸. Eskasoni started its growth in 1940's when Department of Indian Affairs issued a policy called Centralization and Mi'kmaq were advised to move to two centralized reserves. This was intended to remove Mi'kmaq from their homelands to open settlement on their lands but was justified as providing better services to them¹⁹. Eskasoni population was moved from just a community of about five main families living in Eskasoni in the early 20th century to its current population of over four thousand people.

Eskasoni's growth has since been gradual as has been the services provided. Eskasoni has had an on-reserve health center since the 1960's, which has provided for a longitudinal analysis of prenatal history. The increasing population of Aboriginal peoples (especially within Eskasoni) creates a stress on all the social and medical services, especially when the Aboriginal population has higher rates of diseases and live under conditions that foster greater ill health overall. Their need for increased medical services is not matched with appropriate services in their communities and outside. This creates a spiral of their having a need but fewer resources, evolving to greater need yet fewer resources.

Two distinct groupings of Aboriginal women stand out in the literature dealing with Aboriginal women's health, those who live in rural areas and those who live in urban areas. Both interestingly have similar trends in their prenatal and postnatal health despite certain advantages in each location. Within First Nations reserve settings in Canada, First Nations women who are registered, as status with their home reserve and the federal government are able to access not only provincial health care but also federal government funded programs for delivery (Bolaria et al.²⁰, p. 151). Thus, First Nations women with 'Indian status' can access on-reserve health programming that is funded through federal government and they can also access off-reserve health programming that is funded by the provincial government. On the other hand, urban Aboriginal women have the benefits of having more health choices and control over their health, as they have greater geographic proximity and access to doctors, hospitals, health programs and health care providers but this does not equal to greater or equal access to services²⁰. All Aboriginal populations have different sets of limitations in Canada, such as isolation or lack of Aboriginal focused health care services, due to geographic boundaries such as

those Aboriginal communities in Northern Inuit communities. Nevertheless, the trends and risk factors for poorer health noted for Aboriginal prenatal and postnatal health are very similar among women regardless of their residency or location of birthing.

The major risk factors for Aboriginal women are many, including issues of poverty, isolation, and housing and over crowding^{14, 20}. Aboriginal women are more likely to be unemployed, single, and living below the poverty line than Canadian women¹⁴. Besides the socioeconomic status of Aboriginal women, they are more exposed to violence within their homes, environmental pollutants and poor nutrition^{7, 9, 10, 14}. The lower socioeconomic status (SES) and poorer the health status of Aboriginal women are conditions that have been linked to historic colonization and patriarchy within Canadian governmental systems²¹. Canadian health services have had strong undertones of blame and victim labeling which creates an uncomfortable position for Aboriginal women. “Epidemiologist suggests that many of these chronic health conditions are the result of forced acculturation imposed on Aboriginal peoples”(Bourassa et al.¹⁰, p. 1). Colonization, marginalization, violence, poverty and acculturation are but a few of the causes of distress that form the damaged psychological health that factor into Aboriginal women’s health^{11, 20}. Aboriginal women face daily immense psychological, cultural and physical challenges that affect their health and present major health risk factors that put Aboriginal women at a disadvantage before even pregnancy begins.

The major known health status factors in Aboriginal women with the onset of pregnancy are mainly physical, such as obesity, nutrition, diabetes, HIV and other infectious diseases. Many of my participants had experienced various health problems during their pregnancies, such as high blood pressure, diabetes, and thyroid conditions. Other non-medical changes such as in the mental, emotional, and spiritual domains occur with the major life changes during and after pregnancies. Very little data or research is published for the Nova Scotia First Nations people in the area of maternal health, which results in a reliance on Aboriginal data from other areas and Aboriginal population groups. In studies of Aboriginal maternal health in Canada, writers note various problems such as lack of good nutrition, higher rates of obesity among mothers leading to gestational diabetes, higher rates of premature births, infant mortality, and higher rates of cesarean section^{7, 9, 20}. These risk factors create a health gap between the Aboriginal

population and the non-Aboriginal population, which puts truth to the saying that the health of children is indicative of the health of their society. Since Aboriginal women were noted as less likely to attend early prenatal care these health problems tend to carry over to their infant⁹. Within Aboriginal populations, infant health and prenatal health care needs to be addressed to help the overall health problems in the population.

There is some variation of birth weight amongst Aboriginal infants in Canada. First Nations infants living on and off reserve have the same rate of low birth weight as the rest of the Canadian population^{22, 23}. However, Inuit infants have a slightly higher low birth weight compared to the rest of Canada²⁴. First Nations infants living on reserve were more likely to have high birth weights compared to the rest of Canada²⁵. The Aboriginal prenatal nutrition literature has emphasized two main factors at birth that can help predetermine the health of Aboriginal infants. These are low birth weight and high birth rate (usually referred to as Macrosomia). “Low birth weight (less than 2500 grams) puts babies at risk for many health problems and death. High birth rate weight (greater than 4000 grams) is also understood as a risk factor particularly for development of diabetes in later life” (Canada prenatal nutrition program²⁶, p. 1). Within the extremes of low and high birth weight lays a large area for researchers to explore. All my participants noted having normal birth weight of full term babies, and the only mention of low birth weight were infants who were premature.

Low birth weight (LBW) is often referred to as a measure of overall health and well being in the later stages of life²⁰. “Several factors are associated with low birth weight, including mother’s age, health, tobacco and alcohol use during pregnancy, and nutrition, as well as premature delivery” (Bolaria et al.²⁰, p. 250). Aboriginal women especially Inuit women²² are in a higher category for giving birth prematurely, which may explain the higher rates of low birth weight among Inuit women. Preterm birth infants are at a higher risk of poor health due to their underdeveloped condition. This underdevelopment can affect their respiratory system, as well as weaken their immune system²⁰. Thus, low birth weight children are also more likely to get infections and other illnesses²³.

Low birth weight has also been labeled as a potential cause of Sudden Infant Death Syndrome (SIDS); however, there is no evidence to say this is a major factor in

Aboriginal infants rates of SIDS. “The relative risk of Indian children dying of SIDS is approximately three times higher than for non-Indian children” (Shah²⁷, p. 169). One study conducted in British Columbia, noted that there were higher incidence of SIDS in First Nations in both rural and urban communities than the Canadian average²⁸. Smylie and Adomako noted in their report, *Indigenous Children’s Health Report: Health Assessment in Action*, that “SIDS has been linked to certain risk factors including infant sleep position, poverty and environmental smoke exposure” (2009²², p. 31).

While low birth weight is a problem, so also is a higher birth weight. Macrosomia is a term generally used to describe newborns with excessive birth weight (over 8 pounds). “Aboriginal women have higher than average risk of giving birth to high-birth weight baby” (RCAP¹⁴, p. 130). In fact, Macrosomia is more common and prevalent in First Nations²⁹, and Métis populations than its non-Aboriginal populations and Inuit populations²⁴. These high weight infants are also more at risk of having birth interventions such as cesarean section, forceps, and vacuum births^{5, 30}. One might think that having a big baby is a good thing as often people perceive big babies as a sign of good health, but as studies have shown, these ‘fat’ babies have a higher likelihood of being born to mothers with gestational diabetes, and are also more likely themselves to become diabetic in the future³¹. This is an important issue, considering that “the prevalence of diabetes increases among Aboriginal peoples with increasing age” (Smylie et al.³², p. 5). From current estimates within a Mi’kmaw reserve of Eskasoni, Nova Scotia, approximately 40% of adult population has diabetes⁴. A few of my participants had problems with gestational diabetes, and struggled with their weight during their pregnancies. Another mitigating factor in newborns having a high birth weight are when their mothers are diagnosed with being obese before pregnancy³³. “Obesity is prevalent in many Aboriginal communities, and obesity is linked to an increased risk of infant Macrosomia.”(Gray-Donald et al.⁵, p. 1247). One study found that out of two groups, Cree Infants and non-Aboriginal Infants, the “Cree infants in the 2 groups on average were 15% heavier than non-Aboriginal infants, after adjusting for gestational age” (Grey-Donald et al.⁵, p. 1249). Another study found that “approximately 8-25% of Native American infants are considered macrocosmic... compared with an incidence of 3-10%

for Caucasian infants” (Caulfield et al.²⁹, p. 294). It would seem that high birth weight credits further investigation when discussing Aboriginal women’s and infant health.

High birth weight infants are linked to another important risk factor of prenatal health for First Nations women, gestational diabetes. Women with gestational diabetes are more likely to have high birth weight babies. Gestational diabetes has been a predictor for later onset of type-two diabetes. First Nations women in Saskatoon, Canada “had twice the risk of Gestational diabetes mellitus (GDM) compared with general population women after adjustment for all other variables” (Dyck et al.⁶, p. 490). Aboriginal women are at a higher risk of diabetes due to obesity, genetic pre-disposition and poor nutrition. Gestational diabetes creates problems for both mother and child, for they are at higher risk of complications during pregnancy, C-sections, and infant congenital anomalies^{14, 34}. A study in the Cree of Eeyou-Istchee region of eastern James Bay reported high rates of gestational diabetes mellitus (GDM) at 12.8%” (Gray-Donald et al.⁵, p. 1247). Gestational diabetes is a critically important factor, as it may help the understanding of the broader phenomenon of diabetes in Aboriginal populations. It may also hold the key for decreasing the occurrence of type-two diabetes in the future by limiting fetal exposure through prenatal screening and prevention programs.

Infant mortality has been used by the World Health Organization as the best overall indicator of population health within a country or nation²⁰. In Canada, Aboriginal infants have higher rates of infant mortality. When examining the most recent data on Atlantic First Nations people infant mortality, one article found that there is “No information about Aboriginal ethnicity on birth or death registrations in these three Atlantic provinces” which does not allow for accurate Atlantic region First Nations infant mortality rates (Smylie et al.³⁵, p. 145). Luo et al.²⁸ found that infant mortality rates (IMR) were 2.3 times higher in rural areas and 2.1 times higher in urban areas in British Columbia for First Nations infants than the overall Canadian /non-Aboriginal IMR rates. “First Nations (Status Indians on-reserve), Status Indians living off-reserve and Inuit IMR ranged from 1.7 to over 4 times the over-all Canadian and/or non-Aboriginal rates” (Smylie et al.³⁵, p. 147). These rates show a remarkable disparity compared to the Canadian/non-Aboriginal average. Clearly Canada has two separate realities in infant mortality. One is how well it is doing on the national stage, the other is how seriously

lacking it is when it comes to Aboriginal populations. These statistics have been raised often on the international stage as a Canadian disgrace. This elevated gap in IMR can be attributed to socio-economic status, to health care access and the national policies for Aboriginal health.

From the various high risk health factors that Aboriginal women face with the onset of pregnancy, it is important to educate and encourage women on the necessity of prenatal care. From many authors, prenatal care has been touted as the most effective way to ward off these major risk factors^{6, 9 14}. However, while this is good advice, it is not always possible and practical in reality, considering women are limited by many different realities both in urban and rural arenas. The evidence about Aboriginal populations and their health and health care use in Canada are not conclusive, as there are problems with reporting and data gathering. It is also important to note that variances exist among regions in accessibility and programs offered for First Nations women. Thus risk assessment cannot be conclusive to all First Nations women in Canada.

Aboriginal women have been documented as not attending prenatal care to the same extent that non-Aboriginal woman¹³. “It was noted that because pregnancy was viewed as natural event aboriginal women often were not motivated to attend prenatal classes or to seek medical care” (Buharski et al.¹³, p. 152). Such an attitude may lend credence to Aboriginal women depending on local community knowledge as their prenatal care knowledge source. This may also be due to their resistance to the western medical profession as well as to the colonization of the birthing process. The systems of traditional knowledge transfer about prenatal health have been interrupted as a result of the erosion and devaluation of traditional medical practices. This is apparent, for example, in the reaction to traditional midwifery, which has lost much of its high status in northern communities, as the government created policies that excluded midwifery in Medicare³⁶. Aboriginal women need to have prenatal education and programming that accommodates traditional knowledge, while implementing new western-style programming with a culturally sensitive model. However it is important to note that access to prenatal care does not change the social determinates of health such as poverty, food security, and housing during pregnancy and birth.

Experiences of Maternity and Childbirth for First Nations in Canada

The health of Aboriginal nations may be dependent on the health of the women and mothers who are the caretakers of the community. The Aboriginal female population is on the rise: In 2001, Statistics Canada found that North American Indian, Métis, or Inuit “females made up 51% of the total Aboriginal identity population” (Lindsay & Almey³⁷, p. 25). According to the 2006 Census, Nova Scotia had identified that there were 12 405 Aboriginal Identity female population and further that Canada had a total of 600 695 Aboriginal Identity female population¹⁵. “In the period from 1996 to 2001, the number of Aboriginal females rose by 22%, compared to a 4% growth rate in the non-Aboriginal female population” in Canada according to Statistics Canada (O’Donnell³⁸, p. 181). Furthermore, Aboriginal women have a higher fertility rate of 2.6 children compared to all other Canadian women of 1.5 children during the period of 1996 to 2001³⁸. In 2006, the Aboriginal birth rate was 1.5 times higher than Non-Aboriginal birth rate in Canada³⁹. Health Canada has also noted the need for medical interventions, disease prevention, screening methods is greater for the Aboriginal compared to the non-Aboriginal population⁴⁰. Researchers have concluded that there is a need for a culturally sensitive health delivery model for Aboriginal people to ameliorate the major challenges in health care^{41, 42, 43}. The existing system of health delivery in Canada needs to address ways to improve the health and lives of Aboriginal women, and subsequently Aboriginal peoples as a whole. Community health issues involving prenatal health encompass a vast area of complex factors of beliefs, values, attitudes, economics, education, and culture that need to be addressed in order to address the future needs in maternal health. Aboriginal women have been labeled ‘high risk’ in their health behaviors⁴⁴ and have had increased ‘surveillance’ during their pregnancy based on their ethnicity⁴⁵. The shocking statistics and reports about Aboriginal women place them at a disadvantage compared to the Canadian population, yet it is uncertain who actually controls the future health status of Aboriginal peoples.

Some of the literature has pointed out that Aboriginal women are not accessing prenatal care to its fullest potential⁴⁶. This lack of use of some of the currently available

systems appears to be not affected by proximity to health care, as one report in the United States pointed out that Native American women who live in United States urban areas are more likely to delay prenatal care than rural areas⁴⁷. In Canada, some of the challenges of providing adequate Aboriginal prenatal care were noted as being related to “[l]imited resources, large geographic distances, varying language groups, and differing cultural beliefs and traditions [that] have all contributed to increasing the complexity of providing everywoman with a safe childbirth” (Lalonde et al.⁴⁸, p. 956). The lack of prenatal care has been a major problem within the Eskasoni First Nation’s reserve, as well, although in the last five years with the introduction of the newly build Eskasoni Health Center and their implementation of prenatal care programs, frequency of use is changing¹⁸. In rural areas in Canada, where there are even fewer resources for local birthing incentives, the funding from the federal government for registered Indians has been thinly stretched. A lack of financial resources is further blamed for “contributing to the diminishment of prenatal preparation and post natal support” in isolated and remote communities of the northern British Columbia in Canada (Kornelson et al.⁴⁹, p. 76). One remedy emerging to resolve some of the prenatal health predicaments have been to return the traditional roles of midwives in Aboriginal communities to provide a holistic, patient centered, and culturally appropriate approach to prenatal health delivery^{41, 48}.

The lack of a culturally sensitive model of health is more widely found in Canada, especially in Northern communities, where traditionally esteemed Aboriginal midwives have been abandoned or legally banned from practice, to be replaced with urban centers where women have to travel great distances from their home communities⁵⁰. This isolation places emotional and economic stress on women and their families and creates resentment among Inuit and other First Nations communities who are subjected to these separation policies and the lack of access to prenatal care^{13, 51}. Mi’kmaw women living in the Eskasoni and the Chapel Island First Nations reserves must also leave their reserve communities to receive prenatal screenings and to give birth in Sydney, Nova Scotia, which is an hour away from their home community. RCAP¹⁴ noted that “long term human health is influenced by what happens in the womb and in the first years of life”, which emphasizes the need for more resources be put into prenatal and infant health and for them to be used when present (p. 127). Couchie and Sanderson looked at policies and

procedures of maternal health in Aboriginal communities and created a list of recommendations, and among them their best practices was a need to return midwifery and maternal care back to the communities⁴¹. Consequently, prenatal health care and education needs to be examined and re-assessed as an essential factor contributing to the future health of Aboriginal peoples.

Looking for epidemiologic data on Aboriginal women resulted in scarce and scattered information about prenatal health in Aboriginal communities. Far less data was found dealing with concrete evidence that would suggest what kinds of methods or approaches exist, including which ones are exemplary and can be considered for other communities, especially for Aboriginal peoples. It is well established that Aboriginal women fall well below the national health standards in Canada in areas such as diabetes, excess body mass, and chronic health conditions³⁹. From literature, a large amount of research discusses the problematic health care that Aboriginal women face due to limitations and barriers ingrained in Canadian health care systems and from their poverty^{3, 14}. Aboriginal women have a lowered socio-economic status, live in sub-standard housing, suffer from marginalization, and are more likely to be exposed to trauma and violence^{38, 52}. These inequalities contribute to an epidemiologic triangle of access, quality, and cost that together evidence a dire need to address important community health issues surrounding reproductive health and pregnancy in Aboriginal nations.

Oral stories and personal narratives are important in exploring Aboriginal people's experiences with their health and experiences dealing with the health care system. Since western medical model of health delivery has only been imposed over the last century, traditional knowledge was for much longer the primary means of acquiring health related knowledge among Aboriginal peoples. However, colonized and western knowledge legitimized as the only source of valuable knowledge to our current society has diminished and eroded Indigenous knowledge. Author and Maori scholar, Dr. Linda Smith, writes in her book *Decolonizing Methodologies*, about the process of colonizing knowledge from Indigenous populations, and the need to reclaim these knowledge bundles to empower Indigenous peoples⁵³. Indigenous languages, oral tradition, and

traditional knowledge are inextricably linked. These traditional stories are key to understanding Indigenous knowledge and the values behind them.

Little is known about Aboriginal women's choices, knowledge's, beliefs, attitudes and values surrounding pregnancies and prenatal care. While the research that has been done in Aboriginal women's beliefs, knowledge, and attitudes in maternal health is limited, what is available is worth noting. In particular, there are two studies that speak to maternal health in Aboriginal settings. One called "Living in two worlds: Native American Women and Prenatal care", outlined a qualitative approach that explored traditional beliefs related to maternal health among Native American women in the United States⁵⁴. The other is the Masters thesis of Jo-Anne Whitty-Rogers, which examines Mi'kmaw women's childbirth experiences that provided a "qualitative study for the purpose of providing new knowledge about Mi'kmaq (sic) women's childbirth experiences which occur in a large tertiary care centre outside their rural Nova Scotian community" (Whitty-Rogers⁵⁵, p. 68). These previous research studies conducted on Aboriginal women's knowledge, beliefs, and attitudes during pregnancy were significant in helping to structure my framework and methodology for this study.

Frameworks for Understanding the Experience of Maternity and

Childbirth for First Nations women in Canada

Cognitive imperialism is a term used by Dr. Marie Battiste⁵⁶ to describe a colonial education experience of language loss and mind control, a case also evident in health care which has caused Aboriginal peoples to devalue their traditional health knowledge over the dominant western health knowledge systems. In maternal health, childbirth has changed from a natural occurrence that was holistic in nature, recognizing spirituality, emotions, and mental and physical aspects, all drawing from the medicine wheel teachings of Aboriginal peoples to Westernized medicalization of pregnancy and delivery evolving into a condition requiring treatment of symptoms, interventions, and medication⁵⁷. This can be seen through the changes in maternal health over the last decade.

Normal childbirth among Aboriginal women was changed from a time for learning traditional teachings about life and life long learning to an event requiring

solitary confinement to medical professionals, outside intervention, and diminishing the family's connections to the birthing process and to the newborn infant. Birthing has proved to be a life changing event for women, their families, and communities; and within the cultural traditions, it has been a way of renewing culture and reinforcing social relationships by connecting the baby to his/her land, culture, language, community and families⁵⁸. This was a time for 'Elder' and communities teachings that have been undermined when women were taken away from their communities and homes to hospitals to deliver their babies, thus denying the women, the father, the family members and community members' participation and learning in this joyous event. Through the early 1900's across Canada, First Nations women used traditional midwives to deliver their children within their communities. Authors Long and Curry noted, in their article "Living in Two Worlds: Native Americans and Prenatal Care", that "Female relatives were considered the most important source of information about pregnancy and childbirth and traditionally were the birth attendants. However, as a result of acculturation, many traditional ways had been abandoned, including the use of tribal medicines and techniques for birth" (Long and Curry⁵⁴, p. 207). As the medical profession has grown and become more accessible, First Nations women have turned to the western orientation of delivery. From as early as the 1940's, First Nations women were sent off alone to hospitals for weeks at a time to have their children, which resulted in slowly eroding traditional birthing practices and the practice of midwifery across Atlantic communities⁴⁹.

In present day, the western model of health delivery continues as the dominant and authoritative method of health care for pregnancy and childbirth. Aboriginal traditional teachings and practices about pregnancy and childbirth have all but disappeared, along with midwifery, as a result of being seen as primitive and a barrier to successful assimilation into the new Eurocentric centered society. Traditional knowledge is in the process of being revitalized and revalued in the academic world. To fully understand the shifting and contested terrain of the maternal experiences of Mi'kmaw women requires a conceptual framework that draws on the many dimensions of the experience and is appropriate to the cultural context in which it unfolds. The medicine wheel represents exactly such a framework and has been used successfully by many scholars doing research among Canada's Indigenous peoples.

Medicine Wheels and Indigenous peoples

“The task for Indigenous scholars and educators has been to affirm and activate holistic paradigms of Indigenous knowledge to reveal the wealth and richness of Indigenous languages, worldviews, teachings, and experiences, all of which have been systematically excluded from history, from contemporary educational institutions, and from Eurocentric knowledge systems” (Battiste & Henderson⁵⁹, p. 5).

Many Indigenous scholars have sought to validate Indigenous knowledge systems within the academy and to create new methodologies to be inclusive of Indigenous worldviews^{53,56, 60, 61}. The medicine wheel conceptual framework has been used by many First Nations cultures in Canada as a means of obtaining culturally appropriate categorizes and organizational frameworks for explaining issues in health and healing^{62, 63, 64}. The medicine wheel teachings have come back into mainstream academia in the last few decades as an appropriate model of Indigenous methodology and ethical research^{65, 66}. Many authors have used the medicine wheel to frame their research making it more accessible and accepted to academic audiences^{67, 68, 69, 70}.

The medicine wheel is comprised of four quadrants within a circle; the circle representing the circle of life and each quadrant equally contributes to a healthy balance. The four quadrants can represent many things, seasons, life stages, earth elements, and human wholeness. The medicine wheel is meant to show Indigenous worldview that organizes and compartmentalizes themes without isolating them into separate quadrants. No matter how they are applied, the four quadrants work together to create harmony in the body, mind, and spirit. “The Medicine Wheel illustrates symbolically that all things are interconnected and related, spiritual, complex, and powerful” (Battiste⁵⁶, p. xxii). Being balanced in all four quadrants of the medicine wheel is key to maintaining a healthy lifestyle in First Nation culture. The medicine wheel framework^{iv} has significance in the Mi’kmaw culture belief system. It is represented in the Mi’kmaw

^{iv} The medicine wheel framework is relevant to the Mi’kmaw peoples, as the symbol of circles with four quadrants are found in the ancient Mi’kmaw hieroglyphic writings as illustrated and translated in David Schmidt and Murdena Marshall, *Mi’kmaq Hieroglyphic Prayers* in various references to sacred and holy. The Mi’kmaw hieroglyphics are among the oldest forms of Mi’kmaw writing systems, evolving from earlier symbols of pictographs and petroglyphs. Many symbols reflect the imagery of medicine wheels, with the circle with a cross in the middle. Thus medicine wheel imagery has been embedded in the Mi’kmaw language and in their oldest writing systems.

hieroglyphics, an ancient writing system that dates as far back to 1600's, but it is important to note that not all First Nations cultures regard the medicine wheel framework as part of their cultural belief systems.

The medicine wheel framework has been used in many health initiatives to help revitalize First Nations culture and holistic ideology into health programming. The medicine wheel framework helps identify health disparities that First Nations people are faced with, which have been linked to imbalances in the individual, the family and the community. Medicine wheels have been used in mental health, diabetes programs, and more specifically to my research maternal health. The Mnaamodzawin Health Services in Ontario have used the medicine wheel teachings to illustrate Anishnabe teachings on maternal health¹. They have created a model depicting life stages of becoming a mother using the medicine wheel, which guides new mothers on the teachings, associated with healthy lifestyle and environment for mother and baby. The illustration used by the Mnaamodzawin Health Services is shown (Figure 1) as a current medicine wheel that is used in maternal health programming for First Nations mothers. Another similar medicine wheel model has been adapted in means of understanding Indigenous worldviews and understandings of maternal health. Within my own research, I have used the medicine wheel model to categorize and explain my findings.



Figure 1: Medicine Wheel for Becoming a Mother¹ from Mnaamodzawin Health Services

There are two medicine wheel themes that are significant to my research: life stages (child, adolescence, adulthood, and elder) and human wholeness (physical, emotional, mental, and spiritual). The life stages used in my analysis were focused on a particular period of women's lives during maternal health, which frame the life stages as follows: 1. Becoming a Woman 2. Teachings in Pregnancy 3. Experiences during Birthing 4. Motherhood and the 4th Trimester. All of these life stages in maternal health will be examined using the human wholeness medicine wheel, as each of the life cycle experiences can be further categorized into mental, spiritual, emotional, and physical. The person's life stage should be seen as one that begins in the circle with coming from the spirit world, as it is believed that all life comes from the spirit world. From conception, to birth, through childhood, to adulthood, and then through to the older years completes the life cycle. In Mi'kmaw teachings, it is assumed that a person will return to the spirit world after completion of the cycle of life. The medicine wheel thus keeps turning, in a

sense, always moving from one phase to another, constantly moving around in a circle and cycle. Becoming a woman can turn into becoming a mother through pregnancy to birthing a daughter to raising her daughter to becoming a woman, who then becomes a grandmother and the wheel goes round and round down through the generations. Human wholeness or balance includes the physical (reality, tangible, continuous), the emotional (feelings, self-reflections, sensations, inner-most thoughts), the mental (thoughts, teachings, lived experiences, beliefs, values) and the spiritual (intangible, creator, divinity, spirit, ideology)⁶⁶. In my research, I use the medicine wheel to inform the data collection strategy (e.g. the types of probes, I would use in a narrative interview), the analysis (the coding strategy), and the presentation and interpretation of findings.

The medicine wheel quadrants can be used to organize participants' maternal health experiences. Many of the women naturally reflected on their experiences touching on each quadrant in turn, while others told their stories circled continually around quadrants as they narrated various events. Women with multiple children viewed each pregnancy as a single event, but noted the similarities in their journeys through each of the four quadrants. The medicine wheel allowed women to tell their 'baby stories' in a manner that was natural and instinctive in a common, if not habituated, way of speaking during the interviews. Each participant was asked if they had any more to add to each quadrant before the interview was concluded, enabling to reflect on their own experiences. This summative opportunity facilitated a balanced approach to the women's stories and provided an analytical framework for the researcher.

Conceptual Framework of the Medicine Wheel used in My Analysis

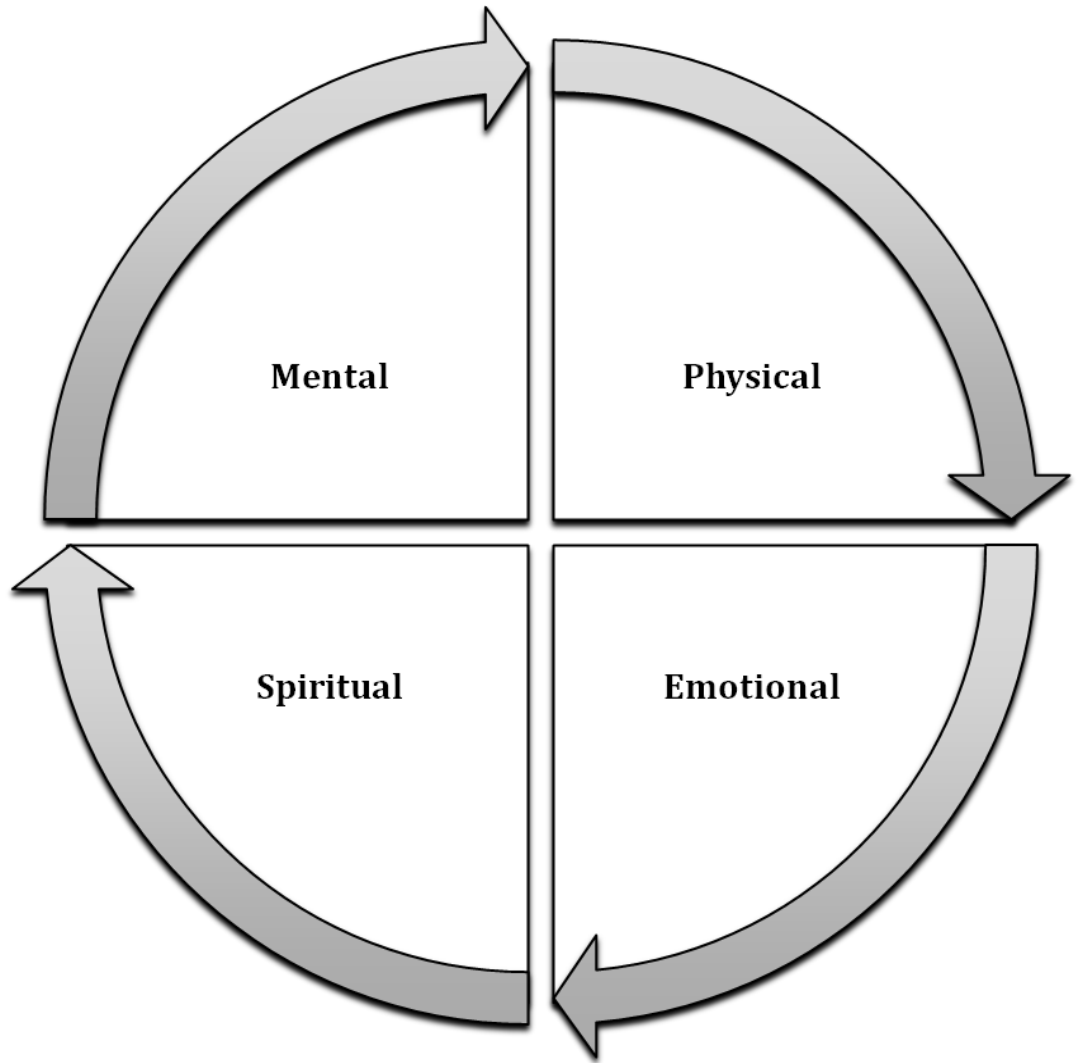


Figure 2. The Human Wholeness Medicine Wheel

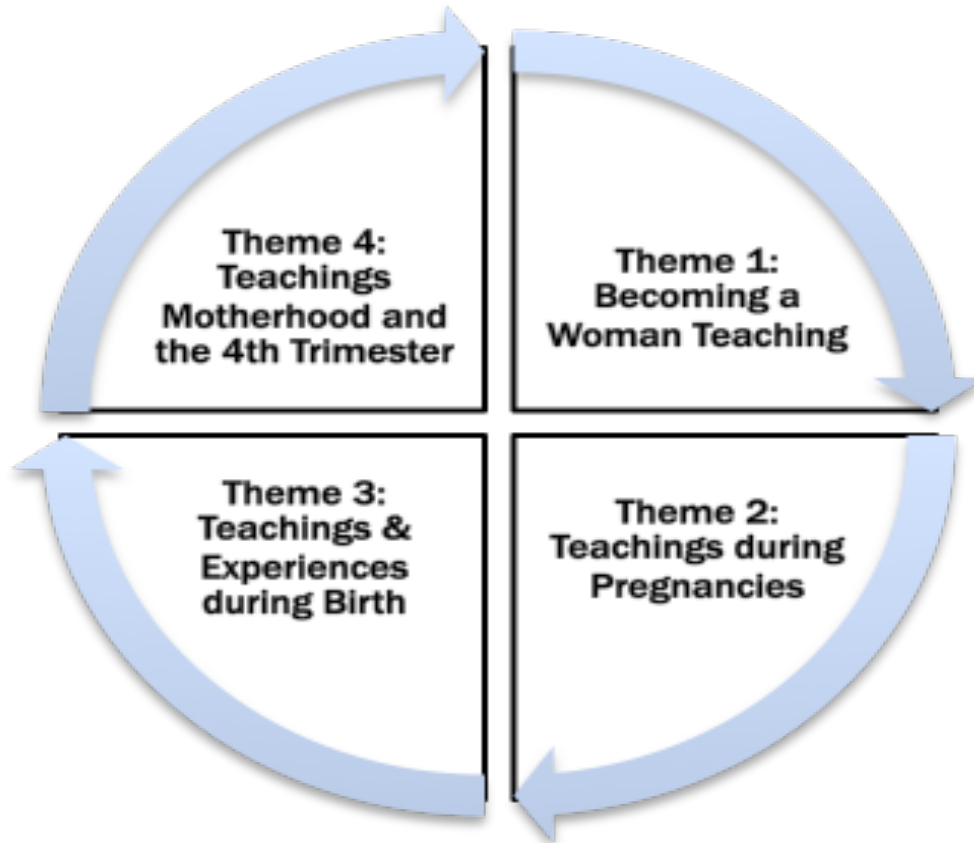


Figure 3. Four Themes Created from the Maternal Health Life Cycle

Chapter Summary:

The focus of my literature review was to examine three main issues: one was the maternal health and healthcare for First Nations women in Canada. The findings lead to a great deal of literature of the health disparities and maternal health problems, which are considerably greater among First Nations women than among Canadian women. The second issue was to look at the experiences of maternity and childbirth in First Nations in Canada. Literature noted the great need for expanded maternal health services that incorporate a more culturally appropriate prenatal screenings for First Nations women in both urban and rural contexts. It also noted that First Nations birth rate is increasingly growing which will create a need in increased healthcare services in the future. The third issue was to examine conceptual frameworks for understanding the experiences of maternity and childbirth for First Nations women. The focus was to look at how the

medicine wheel is used to understand the First Nations maternal health research. The literature surrounding medicine wheels promote Indigenous worldviews and understandings towards holism and inter-connectiveness in health, which could provide insights into maternal health experiences. The framework that I used was fairly simple compared to other, more elaborate, medicine wheel frameworks. Within my data analysis, I focused the medicine wheel framework in two models, the first of which is the human wholeness wheel, which consists of the physical, emotional, spiritual, and mental components of health. The second model is of a life stages theme of women during pregnancy, which consist the following life four quadrants: becoming a woman, pregnancy, birth, and motherhood/post-natal. These models layered together create the framework for my analysis and findings of maternal health knowledge, attitudes, and behaviors of the Mi'kmaw people.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter presents the communities in which the research was done, re-introduces the research objectives and questions, discusses the narrative methodological approach that framed data collection, provides an overview of the complex ethical approval process, and concludes with the analytical strategy drawn from the medicine wheel discussed in chapter two. Throughout I also address the struggles that I had bridging western ways of research and my own Aboriginal belief systems. Dr. Linda Smith⁵³ and other Indigenous scholars^{67, 69, 71} have raised concerns about research that has been done on Aboriginal peoples. Too often Aboriginal perspectives have not been considered in the methodology, in the data analysis, and in the conclusions. In my research, I have applied western methodologies (narrative inquiry) within and appropriate to an Indigenous framework informed by the medicine wheel. The researcher (me) is Mi'kmaq as are the participants. As such this is research that is done by Mi'kmaq, using an Indigenous framework, working with Mi'kmaq participants for our collective benefit.

Community Context

The Mi'kmaq communities (Figure 4) in Cape Breton Island from which I drew my participants have a long history within Nova Scotia. Atlantic Canada's First Nations have the distinguished position of being the first to have had contact with European settlers, and therefore a long colonization experience. The Mi'kmaq were able to keep much of their traditions alive through their incorporating cultural customs and values with missionaries' beliefs and practices, which integrated Catholic religion with traditional spirituality. The respect that the Mi'kmaq and the missionaries had for each other created the foundation of the Mi'kmaq Peace and Friendship treaties of 1725 and 1752⁷². The Mi'kmaq sought to have peace and brotherhood amongst the new settlers who arrived in the seventeen hundreds. Thus the Mi'kmaq have been in contact with settlers, missionaries, and Europeans in general for many centuries, but have been able to sustain and evolve their cultural values and beliefs through time.

This research was initially intended to include Mi'kmaw women from all five of the First Nations communities in Cape Breton; however, time constraints and convenience led to the study being completed with two of the five Mi'kmaw communities in Cape Breton: Potlotek and Eskasoni. Potlotek is the ancient Mi'kmaw name for the area, but was named by the government of Canada as Chapel Island First Nations Reserve, and as such, I use these words interchangeably. Since my ancestral family on my mother's side is originally from Chapel Island reserve, it was appropriate that I gather information from this reserve. Chapel Island has a population of about 500 people with an average birth rate around ten births per year^v. Potlotek is a smaller reserve with a land area (square km) of 5.6 km⁷³. Since Potlotek First Nations reserve is one of five Mi'kmaw reserves in Cape Breton, but is significant to the Mi'kmaq as it has special historical and cultural significance. Before 1850, Malagawatch was the capital of Mi'kmaq Nation and after 1850, the traditional meeting grounds were moved to Chapel Island where Mi'kmaq people met regularly with their traditional government, The Grand Council, known to Mi'kmaq as the Santé Mawio'mi (Sacred Gathering) on a small island, accessible by water to all the other districts of Mi'kma'ki. Potlotek is the surrounding territory of this traditional meeting place, now a reserve where its residents have been known as the guardians and caretakers of the traditional lands and their ancestors who are buried on the island. Like the rest of Cape Breton, Potlotek is rural and isolated and has a high unemployment population of 34.3% as indicated in 2006⁷³. It is approximately an hour's drive from Eskasoni First Nations.

Eskasoni First Nations is the largest Mi'kmaw reserve with a population nearing four thousand residents. Statistics Canada estimated their population at 2952 people in 2006⁷⁴. However, this figure from Statistics Canada does not include the seasonal flux of community members from other reserves who tend to move to Eskasoni during summer and winter months for schooling, recreation, and other visiting done regularly among the people. Most of the data and interviews for this research were collected on the Eskasoni First Nations reserve, however there was one interview conducted in the community of Potlotek. Eskasoni was primary location, as it has a larger population and because the

^v The birth rates of Chapel Island and Eskasoni First Nations reserves were gathered through previous knowledge of the communities as well as through research featured in the unpublished document I produced called, *A Feasibility Study of Midwifery in First Nations Communities in Cape Breton*.

researcher lived in this community. Eskasoni has a birth rate that averages around 75 to 100 births per year and 50% of the entire population in this community is under the age of twenty-five^{16, 17}. Eskasoni is also known as a leader in maternal health and health delivery since the 1960's when the community built their own health center within Eskasoni and staffed it with nurses and doctors. Eskasoni Community Health Center then has been pivotal in making health care accessible to the members of the community.



Figure 4: Mi'kmaq First Nations Map⁷⁵ from Government of Nova Scotia Aboriginal Affairs.

Characteristics of Participants

The participants in this research project were drawn from the Mi'kmaw population in Cape Breton, Nova Scotia from two First Nations reserves. They were delimited by location within Eskasoni Reserve, where I was raised and within Potlotek Reserve, which is the ancestral home of my maternal parent and where I went to school in my early primary years. Since I am from these communities and speak the Mi'kmaw language, I was able to gain access to respected female Elders and community members who felt more comfortable speaking in their first language about their birthing stories.

Their experiences and life histories can be understood within a collective cultural context of Mi'kmaw people, which has been part of my life as a member of the community and as a researcher. This has allowed me to have more understanding of their experiences and the collective experiences of Mi'kmaw women covering maternal health history in the last fifty years.

Overall fourteen Mi'kmaw women participated in the research project: six participated in a focus group and eight participated in individual interviews. They were all women who currently lived on reserve within First Nations communities in Cape Breton, Nova Scotia. The participants were delimited to women who had at least one Mi'kmaw parent, were mothers who experienced pregnancy and childbirth, whose age range was between 21 to early 70's. Most participants, with the exception of two, were under the age of twenty-one at the time of their first child. At the time of their first births, most of the women were on social assistance or unemployed and drawing on their parents' support for their financial needs during the months of their pregnancy. The participants also had a keen interest in maternal health, which led them to participate in my study.

All women self identified as Mi'kmaq and as status First Nations persons. Status is a term used in the Indian Act to designate persons whose ancestral lineage qualifies them as full members as Indians as recognized by the Department of Indian and Northern Affairs. Full status qualifies one to be recognized as a band member within a First Nations reserve as recorded by the Department of Indian and Northern Affairs. Two participants had mixed parentage, as one of their parents was not First Nations and the other was Mi'kmaq. In Mi'kmaw territory, regardless of government laws, one's identity is not based on blood quantum but rather is traced by family lineage and connections to those families. As such, Mi'kmaw descendants are regarded as belonging to the one nation rather than separate entities based on blood quantum^{vi}. In Canada, I could be considered a mixed blooded First Nations person, as my father is a Native American from

^{vi} Since 1985, when many Mi'kmaw women have regained their membership within First Nations communities, although their children now have a distinction of being a 6.2 Indian under the *Indian Act*. The women retrieve their status as 6.1 Indians although they can only pass on a 6.2 status to their children if they have a non-Indian spouse or partner. This may be confusing to some, but as a Mi'kmaw woman with a Chickasaw father and a Mi'kmaw mother, it's easier for me to grasp. I am a 6.1 Indian but my sister who was born after 1985 is a 6.2 Indian.

Oklahoma and my mother is First Nations from Canada. But when I am in Mi'kmaw territory, the only important aspect of my identity is my relationship with my Mi'kmaw family and my Mi'kmaw culture. Thus, how one positions oneself within a family or community verifies one's identity regardless of blood quantum. Two of my participants have one non-Aboriginal parent and one Aboriginal parent, but they have retained First Nations status, Mi'kmaw band membership and are considered Mi'kmaq by the community.

Delimitations/Boundaries

The study was thus delimited to fourteen Mi'kmaw women, aged 20 to 70+, from two First Nations reserves in Cape Breton, Nova Scotia, Canada, all of whom are First Nations status women who had experienced at least one birthing of a child. Using a small sample is advantageous when one is seeking rich qualitative data collection and analysis, but one of the limitations of the sample is that it is not possible to generalize to the entire Mi'kmaw population in Cape Breton, Nova Scotia. I chose two First Nations reserves, one that had the largest population (around 4000 people) and one with a relatively small population (around 500 people). Since the results are very specific to these two populations, it is not possible for me to generalize their experiences in maternal health, but rather it was more important for my questions to focus on the participants' rich stories, understanding the context of their birthing, and their perceptions of Mi'kmaw maternal health knowledge transfer.

Research Objectives and Questions

As research and literature on First Nations women has been sparse, this study contributes in a significant way to the research on First Nations women's maternal health and the care they received. By bringing to the focus to the voices and the experiences of Mi'kmaw women from the Eskasoni and Potlotek First Nations in Nova Scotia, this study has sought to share their values, attitudes, and decisions about their health care when pregnant that could better inform health services.

The objectives are as follows:

1. To gather knowledge about the pregnancy, childbirth, and new motherhood experiences of Mi'kmaq women in Cape Breton, Nova Scotia that can inform the development of an appropriate maternal health programs and services for these women.
2. To contribute knowledge about a framework that incorporates the traditional- and western-informed First Nation experiences of maternal health to the literature, filling an identified gap.

The objectives are addressed through the following research questions:

1. What are the experiences of maternity and childbirth for Mi'kmaw women over the last fifty years (1960-2010)?
2. How is Mi'kmaw traditional knowledge about pregnancy and prenatal care learned among Mi'kmaq women and what significance does it have for health care among women in the First Nations communities of Cape Breton?
3. What are the complementarities and conflicts between Mi'kmaw knowledge and practice and western knowledge and practice and health experiences of maternity over the last fifty years? How do these knowledge systems interweaving together affect Mi'kmaw women's decision-making process during pregnancy and birth?
4. What are the implications for improving maternal health care that would reflect the values and beliefs about pregnancy and childbirth for Mi'kmaw women?

Narrative Methodology

My research methodology draws on narrative inquiry, which is considered a culturally appropriate way of doing research within Indigenous communities^{70, 76, 77, 78}. “A major challenge to researchers who wish to work in Indigenous communities is the collaborative identification of research methods, inclusive of Indigenous ways of knowing, that lead to sustainable, efficacious services that redress health disparities among Indigenous people without violating their rights” (Cocharn et al.⁷⁹, p. 26). While narrative inquiry is understood as a western methodology of data gathering, it is a methodology that closely aligns with Indigenous storytelling in natural ways and has

been well received as a means of gaining knowledge from participants⁸⁰. Recently, Indigenous scholars have used narrative inquiry as a means to recreate Indigenous methodologies in the academy and to hold to oral traditions that favor this type of research methodology⁸¹.

Narrative inquiry seeks to understand the participant's experiences, and life histories as told to the researcher during interviews. Narrative inquiry in qualitative health research focuses on stories or narratives and personal lived experience of the participants. Narrative inquiry can study epiphanies, rituals, routines, metaphors, and dreams, which can all be in the context of everyday lived experiences⁸². Narrative inquiry is considered one of the better approaches to interviewing in Aboriginal communities as it allows oral traditions or story telling to emerge from the natural flow of conversation⁸¹.

In this study, participants are able to share their personal stories of maternity and childbirth without the imposition of a preformed set of questions (Appendix G), allowing for areas of relevance to unfold that were not anticipated from the literature review. While the narratives emerge in free flowing form, often uninterrupted, the researcher is still able to direct conversation to discover particular aspects of the maternal experience (e.g. traditional teachings about maternity and childbirth and the means through which they are learned from one generation to the next), as well as probe for experiences or narratives on all four quadrants of the medicine wheel (physical, mental, spiritual, emotional). When these themes did not come up in the natural flow of storytelling, I followed the narrative with a semi-structured series of questions to draw these topics out. The goal of this narrative research as a process (collecting the stories) and as a product (the study itself) was not to make generalizations or look for approaches that could be used elsewhere in conversations but to seek in the stories themselves the patterns, connections and relationships that are contained within a specific context.

Participatory Action Research (PAR)

At the beginning of this research, I had targeted and planned for Participatory Action Research (PAR) approach with my participants as the literature suggests that this is an appropriate approach to research in Indigenous contexts^{83, 84}. A participatory

action research process allows for local community members to have an opportunity to direct the focus of the research to areas of their need and the opportunity to read and learn of the progress of the study and how the data can be read and analyzed so that their voices or perspectives are included⁷⁹. The research process thus allows for participants' on-going engagement with the topic and an outcome that could effectively make some progress toward some change, either in the participants themselves or in the systems they seek to change. The end goal might thus empower participants' self-efficacy or agency or make them proud of their involvement in the research process. Participatory action research can allow participants to identify their concerns with maternal health and empower them to become active in promoting change toward a Mi'kmaw integrated health care model. However, after many efforts and many attempts at working through these western-informed processes of engagement with the research, the participants were persistently hesitant to engage in a western style participatory action manner, indicating rather that they trusted me to use their contributions to the study appropriately. As a community insider, they were looking to me to move the desired actions.

As a Mi'kmaq community member living in Eskasoni and also being a member of the Potlotek First Nations, I was already engaged as a family member, neighbor, and friend, who had a history of involvement in maternal care. The ongoing insider relationship within the community leaves room for what I would argue is another, perhaps more Indigenous, type of PAR. The research findings are a combination of the researcher's knowledge and teachings about Mi'kmaw maternal health and the participant's knowledge, teachings, and experiences in Mi'kmaw maternal health. The researcher's knowledge is a result of being a community member, brought up in a traditional family, and was taught as a part of my traditional upbringing. I also was engaged in another research study focused on midwifery simultaneous to my thesis research, funded by local funds on reserve. My analysis in this study then is a combination of my specialized maternal health knowledge from my grooming process of becoming a Mi'kmaw community member and the knowledge granted by the participants' interviews in this study. Thus I have become my own

informant, in the research results, and I add my own teachings, understandings, knowledge, and insights to the data set.

While conducting the research, I was able to create both an insider and outsider position. The insider perspective of the research came from my being a member of both communities—Potlotek and Eskasoni—one by my ancestry and the other by my living in my family home in Eskasoni, and my being a Mi'kmaw speaking member, able to understand/speak the traditional Mi'kmaw language. This dual position could have created drawbacks or blind spots in the research by being too closely situated to the participants, who may have consequently been hesitant in disclosing certain details of their experience. Also by being an insider, I may have missed specialized cultural knowledge that to me is common knowledge from my upbringing. Such specialized knowledge can be taken for granted from 'an insider position', therefore more challenging to categorize or reflect as unique knowledge to Mi'kmaq people.

In some ways I could also be seen as an outsider, one who left the reserve when I was in the sixth grade to return sixteen years later with an education and conducting research using western methods of gathering data. My outsider status was lessened by several factors: that I returned every summer since my initial leaving, that I have continued to learn and grow in the Mi'kmaw language over those years, and that I am known by many families because of my parents' work in the community that has been sustained over the years in diverse ways. I also was privileged due to being exposed to Indigenous knowledge discourses and awareness of social and cultural contexts and traditions of many Aboriginal communities from my parents work in these areas. The outsider position could have led me to be seen as someone who had to gain trust and to have to seek more relationship building with potential research participants, but I found as participants emerged, much of the work of trust building had already been achieved. Most of the participants were uncertain and confused with the confidentially processes required by the research and by the research process in general. Recognizing these insider/outsider blind spots were important considerations during the writing stages of this thesis.

As my research work was unfolding, I was recruited and hired to investigate the feasibility of midwifery in the five Mi'kmaw communities of Cape Breton. The work that continued over twenty months created an unexpected dynamic that further enhanced my participants interest in this topic and in maternal health care in general, building a relationship that has remained long after their interviews for my thesis research were completed. They continued to speak with me about maternal health concerns, new maternal health experiences, and ask questions about how the research was progressing. This relationship has allowed for the participants to speak about many aspects of the research and to hear and to input on the conclusions and recommendations. In this less formal way, the thesis research participants continue to shape and help create the analysis and the findings of the research.

Ethics Process

The ethics approval process of this research project was complex, as it required approval from three groups. The first was with *Mi'kmaw Ethics Watch*, the next was through the University of Saskatchewan, and the last was with a local community health board. I had made contact with most of the key stakeholders about my thesis before my writing a proposal for my department. I wanted to be assured that I would be allowed to work within my home community in Nova Scotia before I started. My initial contact was with the community health centers directors and the Health Board representatives in some of the reserves in Cape Breton, Nova Scotia. The next step was to talk to respected female Elders from my home community to whom I previously spoke for support and approval of the project. It was only after I spoke with three female Elders^{vii} about what the thesis was about and after they agreed that I was on the right track did I follow through with writing my research and ethics proposal. I followed up with consulting with my supervisors on the best methods of research within an Aboriginal setting. They advised me of the appropriate methodologies for the type of research that I talked about conducting within the community. From there, I started to create my first proposal for

^{vii} Elder capitalized is significant to describe an Aboriginal elderly person who has knowledge and understanding of the traditional ways of his/her culture and their spiritual traditions. Elders are considered to be most respected members of Aboriginal culture thus it is emphasized through capitalization.

approval by the Department of Community Health and Epidemiology. Once the proposal was approved in the department, I moved on to create a similar proposal for the *Mi'kmaw Ethics Watch*.

First Ethics Process

The first ethics proposal was sent to the *Mi'kmaw Ethics Watch (MEW)*. The Grand Council of the Mi'kmaq established the MEW in July 25, 1999⁸⁵. The MEW provides principles and guidelines for researchers conducting research among Mi'kmaw people and the procedures are available on line at Cape Breton University where it is administered⁸⁵. MEW is a process that ensures that the research has culturally appropriate methods in place to safeguard Mi'kmaw traditional knowledge. It also ensures that any proposed research will consider community protocols and that the process of conducting research and receiving informed consent is completed in an appropriate manner.

I sent my proposal to the Mi'kmaw Ethics Watch in mid-February of 2007. The process of approval requires that three committee members approve the research proposal and then the director of the Mi'kmaw Institute from the University of Cape Breton, sends a letter of approval. I received my approval letter from the Mi'kmaw Ethics Watch Committee on March 26, 2007 (Appendix A). After I received approval from the Mi'kmaw Ethics Watch, I was able to create an ethics proposal to the University of Saskatchewan. The approval meant that I had the Mi'kmaw research community consent to work within our First Nations reserves.

Second Ethic Process

I applied for the University of Saskatchewan, *Behavioral Research Ethics Board* (Beh-REB) on February 27, 2007, following a standard application process. Final approval was received on April 2, 2007 (Appendix B). Meanwhile, I moved to Nova Scotia to wait on these ethics approvals. After I received the approval from the U of S Beh-REB committee, I met with the Director of Eskasoni Health Center in Eskasoni, the largest Mi'kmaw community in the Maritimes. This was the first official meeting that started my thesis process. However, it also led me to my third level of Ethics approval.

The director asked me to acquire approval from the Eskasoni Health Board Committee before starting any research in that particular community.

Third Ethics Process

I met with the Eskasoni Health Board Committee on April 12, 2007 at their regularly scheduled monthly meeting. The Eskasoni Health Board Committee is comprised of members of the community of Eskasoni. A large majority of the committee members were First Nations, most of who had some background in health or administration within the community. There were also Elders present at the meeting, as advisors to the board. Before our meeting, I sent them a copy of the MEW proposal. At the meeting, I offered a half-hour presentation on my thesis proposal and ended my presentation by asking for their permission to work within Eskasoni First Nation community. The Committee members then asked several questions and then took a vote in my presence. They all approved the project as planned. Board members asked me to return with a PowerPoint presentation at the end of my study. I was finally able to begin recruitment and data collection. The final presentation of my study to this group is pending final review of the thesis.

Reflections on the Ethical Approval Process

The ethics process was a time consuming procedure, but in moving through it, I learned a great deal about what is expected from different research ethics committees. Aboriginal peoples have had a historical experience of research conducted either unethically or insensitively^{53, 59, 78}. I was glad to know that there is significant local oversight of research conducted in our communities to preserve culture and human rights of the Mi'kmaw peoples. I became even more aware of my own location as a Mi'kmaw person and researcher, of the value of relationships, of reciprocity in the nature of information exchange, of gift giving for story, and of maintaining good relations with Elders. These values and my adherence to them eased my transition into the researcher role among my people and in my home community.

Participant Recruitment and Study Initiation

While I was waiting for the ethics approvals and living in the community, I attended various gatherings where I wished I had my tape recorder and the ethical approvals in place to gather data. People had already heard of my research plans and began, informally, to tell me of their pregnancy and birthing stories. Once they got started, their stories and conversations would go on for hours, as each story stimulated other women sharing their stories. While I could not include these stories as data in my thesis, they did give me an idea of where to go with my questioning once I was able to begin. When ethical approvals were finally in place, I began formal recruitment with posters around the community and at the health center on both the primary health side and the prenatal health side. I also extended verbal invitations to women who had already expressed an interest in my work.

Local protocols with interviewing Elders and Mi'kmaw women

At the beginning of the study, I was aware of ways that were common to approaching community members and Elders, but doing the research and being aware of what it meant to adhere to local protocols brought new awareness to the importance of various practices. The fact that I was coming from the community in which the research was done had provided a foundation for knowing the Indigenous protocol when interviewing female Elders. The researcher took great care in ensuring that Elders were included so that they too could participate in sharing their personal birthing stories. The researcher did numerous visits to Elders, first social visits to renew and develop relations, to have tea, and then later to talk about the thesis project, and asking their input on the proposal writing stages. All the Elders were viewed and treated as teachers although there were specific Elders who had been viewed in the community with specialized knowledge in certain areas. They are known by insiders as the ones that are called upon often to deal with women's issues, especially dealing with healing and medicines. These Elders were asked for their guidance in the early stages of the project. Once the thesis project was finally approved, the researcher moved to Nova Scotia and started to acquire knowledge

using traditional methods of relationship building and honoring Elders by following certain protocol.

When approaching a Mi'kmaw Elder for information or knowledge, a researcher must be patient and willing to put in the time necessary to prove that they are worthy of the knowledge. The Elders who did participate in the study were visited more than twice before any of the recordings were done. An offering of tobacco pouch was presented at the time of the interview, as it proves that you are willing to offer something for the knowledge. After the recorded interview, a gift (gift certificate) was offered to show appreciation of the gift of knowledge and illustrates the reciprocal nature of knowledge and gratitude. At almost all interviews, food and beverages were provided either by the participant or the researcher. This showed the participants that they would be cared for during interviews and that there was no rush to complete the interview, in essence to say, "I have all the time needed to hear your story; tell it as you please". This often led to visits that ranged from two to four hours, sometimes longer for the visiting after the formal aspects of the interview were completed.

The protocol of eating and drinking tea was also observed at Elders' homes. Once an elder or community member offers tea, it is important that one accept the hospitality offered which also indicates they are willing to talk with you further. A visit is over when tea is no longer offered, indicating to the visitor that one was tired or done for the day. This is a traditional protocol that can be observed in traditional people's home. The offering of food and drink was historically given to visitors to show hospitality and to indicate when and how long they can be expected to stay. If one left too early, one would be encouraged to stay for another cup of tea. Often the researcher would follow traditional protocol in regards of not refusing food or drinks, as it would be a sign of disrespect to their hospitality. It was important to know when traditional protocol was to be followed while conducting interviews and during relationship building before the interview. There is a fine line between being a welcomed guest and being a burden on your host's time and generosity, however, and one must be sensitive to watch for subtle cues from Elders about when the visit needs to end.

Another Mi'kmaq protocol that was observed was to continue the relationships with the Elders in the study well after the interview was conducted. Many of the Elders

that were participants remain as close friends and knowledge carriers. I still make visits to their homes, bringing gifts of baked goods and other items to renew relationships. With all the other participants, the researcher has remained close with them during the research, analysis, and writing stages of the thesis. Since the researcher is an “insider” of the community it has been easy to maintain relationships and keep them updated on how each participant’s life has changed since the interview process. The participants often ask about the research and the findings, and recognize me as a “baby whisperer” or as the maternal health expert, as I have continued to be a present maternal health professional in the community.

Selection of the Research Participants

Recruitment Process

In the process of recruitment, I used many tools to inform the communities of my project. I began with a poster campaign (Appendix C), putting up posters of my research in local businesses in Eskasoni First Nations reserve and sent it out in a community newsletter in the Chapel Island First Nation reserve. I put these posters up at the First Nations health centers with rip-it tags with my information on it, asking if there were any who wished to talk further about the research or who would be willing to be part of that research. I met with health directors and emailed maternal health professionals to ask if they could identify any potential participants that may have special interest on the topic of Mi’kmaw maternal health. Potential participants were asked to contact me, the principal researcher, via telephone, person-to-person contact, or e-mail. Participants outside of Eskasoni, Nova Scotia, were invited to call me and invited to call collect, if necessary. This process of recruitment had very minimal effect on the number of participants as most women did not see themselves as experts in maternal health nor thought their experience was any different from any other woman in the community. It was only through person-to-person contact that I was able to obtain the majority of my participants.

Selection of the Participant

The study used non-probability methods⁸⁶ of selecting the participants to ensure a diverse set of participants. Non-probability methods does not use random selection, as participants were selected for the purpose of finding a diverse target sample of women with a particular experience in certain location⁸⁷. Sampling methods of Mi'kmaw women participants used snowball sampling and convenience sampling⁸⁶ whereby participants are included based on their willingness to be involved in participatory action research methods and their experiences during pregnancy while living on reserve in Nova Scotia^{43, 88}. The sampling method for participants, was done through purposive sampling method⁸⁹, where the participant is deliberately selected based on their knowledge of Eskasoni maternal health history. The participants were all selected based on their location and willingness to speak about their maternal health experiences.

The snowballing sampling method⁸⁶ was used to identify participants. Snowball sampling asks subjects to provide names of others who may be interested or who meet the research criteria. The snowballing sampling method asks selected subjects to provide names of others who may be interested or met the research criteria. . This form of sample provides greater flexibility to my inclusion criteria. Snowball sampling and purposive sampling then became the primary means for selecting individuals who had other particular characteristics, in particular having had experience with maternal health and traditional Mi'kmaw values. The participants are between the ages of 20 to 70 who have birthed at least once, and are of Mi'kmaw or mixed heritage Mi'kmaw background. The focus group participants were all selected with the snowballing sampling method, whereby one person informed the researcher of all those who might be interested in the research.

Informed Consent Processes

The informed consent process consisted of three steps: speaking with the participant about the research and the expectations/responsibilities of becoming a participant, a signed consent form at the time of the interview and a signed transcript release/identifying quotes form. The participants would have a discussion with the

researcher at the time of recruitment and at the time of the interview about their rights as a participants and what will be expected of them in the upcoming months. The participants would then sign the consent form and the interview would proceed (Appendix D: Consent form for Individual Interviews). After the interview, the researcher transcribed the interviews and returned the transcripts to the participants. The participants were given an outlined sheet with their transcripts of the three steps, and were asked to read over their transcripts to edit, alter, or delete any information they felt uncomfortable sharing with others. This allowed the participants to have the power over what would be used and what information was released after the first interview. The participant would then sign the transcript release form and form that identified specific quotes used in the study and returned it to the researcher (Appendix E: Transcript Release Form). The informed consent process was over at this point, when all three forms were signed and the participant was given the opportunity to change, alter, and add to the transcripts. From this point, the edited transcripts were added to Atlas-ti program to start coding and analysis.

Focus Group Processes

Getting the Group Together

In my initial proposed methodology, I planned on putting together two focus groups to discuss Mi'kmaw women's perception of their maternal care and what Mi'kmaw folk knowledge was transferred to the participants during pregnancy. However getting a focus group together was considerably harder than I imagined. I had one failed attempt at a focus group, where I handed out invitations in a flyer format and got no response from the women. In my second attempt I realized that I needed to engage a more personalized approach to getting participants. Since I had interest from one participant, I asked if she would feel comfortable in a focus group setting. After she agreed to the focus group, I asked if she would feel comfortable in taking on a leadership role, in helping me recruit others for the focus group and to help with keeping discussion on track. She agreed and became an informant type participant and also a discussion leader. I spoke to her about my goals within the focus group and what type of participants

I needed. She was also fluent in Mi'kmaq and could help with translating to the participants any of the information shared with her.

The informant participant and I agreed upon a date and time in which we would approach others for the recruitment of the focus group. At that event, we went forward in seeking participants while visiting/phoning women she and I knew. The participants we first approached were the informant's elderly female family members and got them interested through her participation. We were able to recruit three additional women from her family to join the focus group. We set the date of the focus group to fit all the women's schedules. The day of the focus group, I called around to the four members of the focus group (including the informant) to make sure that the focus group time and meeting place was confirmed. One participant asked if she could bring a friend, and I agreed to allow more people into the focus group.

After all the women arrived to the focus group, we had six women in total. Three of the informant's family members who originally signed up in our initial recruitment showed up, and they brought along two additional women who were not briefed on the focus group in the initial recruitment strategy. This number of participants was quite larger than expected, but I was happy to get a positive response since recruitment was a struggle in the first attempt to do a focus group.

The women who participated in the focus group were not participants in the individualized interview process. They all fit the criteria of being (1) Mi'kmaq decent, and (2) having experienced pregnancy within a First Nations community. The interesting part of the focus group composition was many of these women were related and were from different generations. I had an Elderly woman (between ages of 60-70+), three women in their middle ages (35-55), and two women in their twenties. This generated a greater diversity in opinions and experiences in maternal health, and the mix of women came together perfectly. The informant participant who was in her twenties also helped lead discussions with probing questions about her families' past experiences and was helpful with questions from her own curiosity. The focus group started out discussion of the research questions in English but drifted back and forth from English to Mi'kmaq, as the participants got comfortable they spoke in their native tongue more

frequently. The group was dynamic and created a great deal of quality information about maternal health history and attitude changes, and personal experiences.

Informed Consent

Once all the women had arrived and had engaged in a community friendship protocol of small talk for about fifteen minutes, I started with the process of achieving informed consent. After the women got settled, I handed out consent forms and pens for them (Appendix F: Consent Forms for Focus Group). I spoke to the participants about their rights as participants and the issue of trust and confidentiality within the focus group. I spoke about what the research will be used for and what my goals were for the focus group. I assured them that their identities as shared at this session would be kept confidential and they would not be identified within my thesis. I also asked that they respect each other's confidentiality and not share the information outside of the group, although I also noted that I could not guarantee that possibility and that they should keep that in mind as they told their own stories. I outlined the consent form for them and asked them if they had any questions further about what they were signing. They all agreed to join the research and signed their consent forms. After the consent forms were signed, I outlined the format that the questions were to be delivered and told them that while I preferred if they spoke primarily in English rather than Mi'kmaq, they could use Mi'kmaq if they wished and I would get confidential translations prepared for the transcripts. I let them know that while I could understand Mi'kmaq, my own speaking fluency was limited. Most understood my location in the community in this regard.

Finding a Location

Finding a location that would make my participants feel comfortable with the research process was an easy decision as there is very limited spaces in which I could (1) conduct research confidentially, (2) have enough room to fit all participants, and (3) have a comfortable environment that would be familiar to the participants. The location of my focus group was done in my home, around the dining/kitchen table. I picked my own home, as other people's homes are often filled with children, partners, and visitors that

often lead to uncontrollable disruptions. Since I lived alone, it was easier for me to control the amount of interruptions and to have my door locked to minimize any visitors. I also chose the dining/kitchen table as the location of research as it is commonly used place for female discussion within Aboriginal communities, and there was food available (cookies, water bottles, tea and candies). The table was where the participants naturally drifted towards without being guided there. Since there were more people than I had chairs, I moved additional chairs from the living room into the dining area so that all the participants were in close proximity to the tape recorder. The open concept room made it possible also that no one was outside of the listening area.

Using an Electronic Tape Recorder

Within the focus group, I asked for only short commentaries on their birthing experience to get familiar with their voices and their experiences. I gave each participant five to ten minutes to discuss their personal experience with pregnancy and birthing, which allowed me to figure out the number of children and any complications during their maternal care. The story of their experiences with pregnancy allowed for richer text than would have been given if it were a question and answering format. In this manner, narrative inquiry worked perfectly to combine both my focused questions on maternal experience stories with additional categories that I had not thought of during the planning phase of my research.

After all the women had the chance to speak to their experiences in maternal care, I started with very basic questions to start conversation about commonalities and differences in their maternal experience. I asked about what attitudes were generated at the time of their being pregnant about Mi'kmaw teachings, and asked them to identify any folk knowledge that was given to them during their pregnancies. The last focus area was then on seeking women's suggestions on how to make maternal health better within their community and any other insights about maternal health they would like to have on record. The focus group lasted about an hour and a half.

Once the entire focus group recording was transcribed, I went to each participant and asked for her to read over her contributions and to make sure that their quotes were

accurate. Some quotes had to be switched around, as I had misidentified the participant with a quote. After they all had a chance to make changes, I edited the focus group transcripts. Once the transcripts were edited, the participants were finally asked to sign a transcript release form. This was a smooth process but took some time to get participants to return their transcript release form.

Interviewing Processes

Interview Process

During the interview process with each participant, I tried to be consistent with each one in how I conducted the protocols of place and informed consent. For each interview, I asked my participants to read over the consent form, and then after they had an opportunity to ask questions and were clear about the process, I asked them to sign at the appropriate places. I reassured them of the confidentiality of their identity in the study and that they would have an opportunity to read the transcripts and change or exclude any identifiers that may have been missed. I told them that I would be returning with their transcripts at a later date. I started each interview with asking the participants if they felt comfortable with the recorder on and then when they agreed I turned on the tape recorder. I then would start by asking a general question: “Tell me about your pregnancies from the time you found out until after the baby was born”. I allowed for as much time as possible for this section until the participants were comfortable speaking. Then I separated the second and third themes of my questions, the first section was basic background of their age, status, and location of their pregnancy, which was covered usually in the story (Appendix G: Potential Questions for Interviews). The second question section was directed to traditional knowledge and knowledge transfer, and the third question section was about their maternal health and medical care. If they had not covered these areas sufficiently in their narrative, I would follow up with these additional probes after the participant told their story. After the interview, I thanked them for their contributions and told them they would have the chance to change, edit, or add to their transcripts when I brought back the typed transcribed transcript release forms.

I maintained contact almost monthly with my participants to update them on the status of my thesis through to the end of the project. The final presentation of the results at a community forum will be provided at the end of the thesis writing process to ensure that everything that is being published is satisfactory for my participants. At these regular meetings, I informed them of the emerging themes, and key findings and they remained very happy with the results throughout the data collection and analysis stages.

Locations

Finding a good location to conduct individual interviews was an ongoing challenge. All participants were mothers and thus had childcare, transportation, and other issues that played into the choosing of a location. Since the Mi'kmaw communities that were involved in the research are often largely populated, homes sometimes had more than one family in it. Thus it was hard to find a space that would be uninterrupted over an extended period of time. Even within my own home, confidentiality would be difficult to uphold, as some of my neighbors would often appear when I had visitors over for casual interactions. It was a struggle to create boundaries in a community that is known for its communal spirit and hospitality. Even with interviews in my own home, where I lived alone, there was always some sort of interruption during the process, for which I would have to accommodate and still maintain the confidentiality of the visit's purpose.

The participants chose their best location for the interview. Some felt more comfortable within their home settings, while others realized the limitations of their home environment. I managed to interview all the elders within their own home, at a time when the family members would not be present, such as during school/work hours. One participant chose to do her interview in her home since she had no childcare for her children, but tried to accommodate privacy by booking a time when the children would be sleeping. All other interviews were done within my home, as many of the participants could not control the number of people who showed up during interviews. I also conducted my focus group in my home around the kitchen table, as this was the most comfortable spot for conversation amongst the six women.

Confidentiality and Anonymity

Identifiable information on participants was not disclosed to anyone other than the primary researcher and the researcher's supervisors, Dr. Janet Smylie and Dr. Sylvia Abonyi. To ensure anonymity in the writing process, a coding system for data collection was used so that the names of participants were not disclosed or put at risk. The transcripts were cleaned of any actual names or textual identifiers, such as the names of participants, family members, health professionals, or acquaintances, locations, dates, etc. as mentioned during the interviews. Since the interviews were done within a small geographic space, the names of the communities of the participant were not revealed as this small sample of women in one community might directly connect them with their stories. All notes and transcripts were stored in a locked cabinet in the office of the researcher, and all electronic notes and transcripts were stored on the researcher's password protected computer.

As individuals in Mi'kmaw communities are often well known to each other, I also had to depersonalize direct quotes in the presentation of research findings. Participants were informed of this potential limitation before signing the informed consent form and before entering into the interview. Direct quotations were only used if the participant had given explicit consent on the informed consent form and had approved of the final draft of the transcript.

However, it was recognized that some risk remained in a possibility that a participant may be recognized through their direct quotations or content, or due to their manner of speaking. Therefore, the participants had the opportunity to review their transcript after their interview in order to request that any information they feel may reveal their identity or compromise them in any way, be removed. Some participants chose to edit out some of their information that was then deleted from the transcripts. This was done with particular sensitivity for anything that may identify an individual, family, or community.

Each of the participants was given the opportunity to select a pseudonym to hide their identities or to select to use their own names, recognizing and being told of the risks involved. However, even though the women who noted they were indifferent about using

their real names and pseudonyms, I decided it was best to give them all themed pseudonyms so that I could categorize the participants by their age categories. The pseudonym was selected created by flowered (Ivy, Rose, Lilly, Violet, Daisy) names and the spring months (April, May, June) names by the researcher. I used flowered names to identify Elder and Middle Age women, as a means of distinguishing them from the younger participants. Flowers were appropriate as it signals elegant and grace, and at the time of bloom a full maturity of a life cycle. Spring is also a time for flowers, so it seemed appropriate to use in conjunction with flowered names. Flowers are also seen as feminine which also allowed identifying all the participants as female. I used the spring month for the younger participants as to show how they are beginning to learn the vast knowledge of maternal health.

Language and Translations

During the consent process, I explained to my participants that if they chose to speak Mi'kmaq that I would be translating their text into English. I also explained that I might hire someone to transcribe in English any Mi'kmaq dialogue that might be more complex. Some asked if I preferred if they did not speak Mi'kmaq, but I responded that they should do what feels natural, as I did not want them to feel uncomfortable in trying to tell their stories or explain only in English. As the interview process proceeded, and as they spoke Mi'kmaq, I would repeat the meaning back to them in English and ask if my translations were accurate to what they were saying. I often checked with my participants so that I would not be confused during the transcription process. This was a valuable tactic as it allowed for them to explain in English if they might have been misunderstood in translation. Most participants only spoke a few phrases of Mi'kmaq in their interviews, which led me to translate comfortably and to not have to hire outside help in translations. Often they referred to traditional medicine or other items in Mi'kmaq but would continue their stories in English.

The use of Mi'kmaq language was a valuable tool as it also situated the researcher as an “insider” and allowed the participants more freedom of speech. Some of the translations were slang and others were long phrases that participants were told during

pregnancy. The elders used Mi'kmaq to repeat what their grandmothers/elder women would tell them during pregnancy. It provided the women with some oral traditional accuracy to say the sayings or phrases in Mi'kmaq, as some of the meaning and context might have been lost in translation. I allowed for this when doing interviews and noted in the transcripts when Mi'kmaq was used and created a code for it on Atlas-ti. On Atlas-ti, I used (*MIKMAQ) as the code for any Mi'kmaw translations, and also help myself identify when I translated.

Questioning

The questions created during the proposal writing stage were often used as a guide and not a strict list (Appendix G: Question Guide). Often the interview process was an organic, free flowing conversation with the participants about their pregnancy, births, and children. Often the questioning period started with the researcher saying, "Tell me about your pregnancy, and birth, from start to finish, from the time you found out you were pregnant until you had your baby". This then prompted the storyteller to go into as much detail as she remembered and only after the whole story was completed did the researcher use more focused probing. The researcher used the questions as a guide to fill in the gaps if the mothers did not speak about certain themes, such as traditional knowledge in maternal health, background information, what advice was given during pregnancy, and what services did they access during pregnancy. These areas allowed for the researcher to find out about areas that might not pertain to the individual baby story, but would be common knowledge in the community such as Mi'kmaw traditional teachings and Mi'kmaw legends regarding pregnancy and birth.

Questioning about Maternal Experiences

The first step in finding out the answer to the question about maternal experiences of Mi'kmaw women was to ask Elders about their experiences and to capture historical aspects maternal care, delivery and procedures. I wanted to be able to compare past experiences (within about 50 years) with the more recent maternal experiences, determining what had changed and progressed in the community's health delivery. I also

wanted to explore the practice of midwifery within the communities; however, many of the women had their babies within a hospital. One participant, however, did remember the local community midwife and her role within the community. She was remembered as being a respected medicine woman. This past history was rich, but limited, as many of the participants were unaware of maternal health experiences of their mothers or grandmothers. Most Mi'kmaw Elders did not speak about their mother's experience, as most women were very conservative about sharing their own personal experiences with childbearing and knowledge was provided only on a need-to-know basis.

All of my participants had given birth at the local hospitals surrounding the reserves, although most of the younger participants were able to receive maternal care within their home communities. One participant had their entire maternal experiences within an urban setting in a major city in the United States. All participants had different ways of accessing maternal care, some choosing doctors over location and others choosing location and accessibility rather than remaining with one doctor. Most Elders had no choice in their maternal care as there was often only one way of accessing health, as well as many of them had not received much more than a confirmation of their pregnancy and then saw the doctor again at delivery. These women were not able to access medical care, as it was not offered to them as Indians at the time or was not as accessible as it is today, as well as other factors like poverty which prevented access to medical care due to lack transportation, childcare, or money for hospital care.

In all my interviews, I asked the women to talk about their own personal experiences with maternal health from the time they found out they were pregnant to the time when they took their baby home from the hospital. As this is the most frequent story among women, especially when another woman becomes pregnant, most women fell comfortably into the story aspect, retelling their experiences in sufficient detail to allow me to understand their background, personal experience, and the context in which they received their medical care. I only interrupted to inquire further on certain details, but otherwise in all instances, I took the role as an active listener, mentally checking off when upcoming questions were answered throughout their story.

Transcripts and Transcript Release

Electronic Tape Recording and Transcription

During my interviews I wrote notes in a journal and then later I reviewed these and the recorded session to add new insights or ask myself questions that might be answered at the end of the project. After the interviews, I copied the digital recording onto my computer, which then I burned onto a CD or DVD and stored it in a locked file.

I personally transcribed all interviews, except for one that was contracted out to another individual who signed a confidentiality agreement. The last interview was contracted out due to time constraints in returning the transcript release forms to participants. After all the interviews were transcribed and cleaned with editing, spelling, and other formatting I went to each participant and left them a copy of their transcripts, a comment page, and the transcript release form. I expected that the participants would read over their transcripts and edit out information they were not comfortable with sharing or remove any identifiers of them. Most participants asked if it would be all right if they just signed it and handed it back. I nonetheless made sure to leave them a copy to read over in case they changed their minds. I also did not pick up the transcript release form for at least a week. When I did pick up the release form, I asked how they felt about being part of the research and if they wanted to add or change anything. Some participants were happy with the transcripts and others asked to delete certain sections or certain identifiers, which then I wrote on the pages of the transcript. After that, I edited their transcripts on the computer based on their requests.

Transcribing Language and Speech

In terms of language used during interviews, I edited out of the transcriptions most of the pauses and sounds. I left in laughter and coded it as [lol] (which is laugh out loud) in my transcripts. I translated the Mi'kmaw phrases/sentences into English and then put a [*Mi'kmaq] code into the text to indicate text that was translated from Mi'kmaq to English. Since most participants spoke minimal Mi'kmaq during the personal interview process, it was unnecessary to hire an outside translator, which I had initially thought would be necessary. I found I was able to translate most of the Mi'kmaw words or

phrases. If I didn't understand a particular word during the interview, I asked the participant what she meant or I would repeat the meaning of the word(s) as I understood it and would receive their feedback as part of the interview. The participant would then clarify their meaning and we would continue on with the interview questions.

Developing a Culturally Relevant Framework for Data Analysis

Analysis was conducted using Atlas-ti software. The coding process was extensive and developed to reflect the medicine wheel framework I presented in chapter two. Experiences were grouped into five major categories; four reflecting the quadrants of the medicine wheel (Spiritual experiences, Emotional experiences, Physical experiences, Mental/Intellectual experiences) and a fifth to capture discussion specific to Traditional Knowledge. The women's stories were further coded in each quadrant to capture details of the experience. Once all the coding was completed, a rich text format (RTF) document was created of each individual code that included all the quotations that were coded under that specific code. This RTF document was then placed under a file name that corresponded with the appropriate quadrant. The "Complications with pregnancies" code for example, was placed under 'physical' quadrant file, so that I was able to identify common and unique experiences under each of the quadrants of the medicine wheel.

Chapter Summary

The research methodology used in this thesis has attempted to respectfully acknowledge and generate an Indigenous worldview and understanding of the participants' contributions, being sensitive to the manner and protocols involved in soliciting their voices and storytelling and to understand more fully how Mi'kmaw women have experienced childbirth and care by those before, during and after their birthing. Every effort was made to incorporate the western academia protocol and the Mi'kmaw traditional knowledge protocol in obtaining the data from the Mi'kmaw female participants. Three ethics process is just an example of the many processes a researcher working in a First Nations context must complete in order for trust to be bridged amongst

a researcher and First Nations communities. My position as an “insider” was an advantage as well as my language ability in Mi’kmaq that allowed participants to speak in their ancestral language in which they felt most comfortable. However, Mi’kmaq people have had colonial languages present around them for over 400 years and currently, most have learned sufficient amount of English (and some French) to function adequately in English. This was not always the case, as in the early 20th century, most people did not have much interaction with local white communities and did not need to function in these languages as much. Few then had enough English to function adequately in those contexts, which led to many prejudices and misunderstandings. My own use of Mi’kmaq language in the interview contexts, albeit not as fluent as they were, helped to build better relationships with the participants, and facilitated the Mi’kmaq knowledge gathering protocols. This positioning and privileging of Mi’kmaq language communication allowed for more participants to feel comfortable with the research process.

The use of a medicine wheel themed analysis using Atlas-ti was another approach in which the methodology has incorporated both the western academic tools and the First Nations conceptual frameworks. The researcher has had to straddle both worlds in order to obtain ethically sound research data that were considered valid in both western academia methods and First Nations traditional methods. The research methodology sought to empower First Nations women’s marginalized voices and provide their contributions to the discussions about maternal health care and to give culturally safe space for women’s traditional knowledge to emerge in their personal storytelling.

CHAPTER FOUR

FINDINGS AND RESULTS

This chapter will explore the findings of the research gathered from the fourteen interviews conducted with Mi'kmaq women in Cape Breton about their pregnancy and childbirth experiences, as well as the maternal health teachings they received in traditional and western contexts. The findings have been categorized by the medicine wheel in two important sections, the life stages model of maternal health teachings and explained further through the medicine wheel teachings of the mental/physical/emotional/spiritual quadrants of a wholeness model. The findings explore how Mi'kmaq women gain maternal health knowledge throughout their lives and show where they apply these teachings during pregnancy. The findings also show how becoming a mother is a gateway into adulthood/womanhood for many of the Mi'kmaq participants. Themes were created through medicine wheel teachings and are structured in a life cycle of age from becoming a woman, pregnancy, birthing, and the post-natal period. The themes structured with four quadrants of the medicine wheel provide the foundation for discussing participants' perspectives in story and anecdotes about how the participants experienced incorporating traditional Mi'kmaq teachings, spirituality, and medical knowledge systems into their maternal health experiences.

Process of Gathering Traditional Mi'kmaq Maternal Health Knowledge Transfer Data

I sought out Elders to learn of traditional knowledge given about pregnancy and birthing, but I came to realize that traditional knowledge is foundational first and foremost in experience and secondly by other experiences shared with them and lastly by revealed knowledge, meaning coming from teachings that are more grounded in mythical figures. As such, each of the Elders would start first with speaking to their own personal knowledge rather than making broad generalizations about what others would know or do. Therefore in the interviews, I had to change the phrasing of interviews into questions that asked them more of what did you hear about pregnancies from other women in your community, rather than what traditional knowledge was passed down to you? Each of the Elder participants was hesitant to put themselves forward or be seen as the expert in

maternal health and traditional knowledge. However, when I altered the question to explore their experiences in a more personalized way, I found that traditional knowledge was present but was offered in a subtle manner. Traditional knowledge involving pregnancy, care, well-being, delivery, etc. was not spoken about directly but participants knowledge stemmed from stories of other community members birth, pregnancy, and motherhood experiences which led to a richer text and data, as both their stories of their own experience and other persons maternal experiences were considered in analysis.

When the younger generation was asked to consider traditional or folk knowledge within the Mi'kmaw context and modern western knowledge as understood as what they experienced in hospitals or with doctors, they were unable to distinguish between these. The participants were able to categorize some the teachings received from their mothers, grandmothers or in-laws as falling into categories such as myth, fact or fiction, or folk knowledge, but they still upheld traditional knowledge practices during pregnancy regardless of their beliefs or attitudes about the categorization. Many of the younger participants said they did not believe fully in some of the Mi'kmaw legends about pregnancy or birthing, but they remained respectful enough of these traditional beliefs for fear of any negative consequences (e.g. something bad happening to the baby) if they did not follow them. With higher levels of literacy in English among the current Mi'kmaw population as compared to their grandparents' education levels when youth had to attend residential schools and had English forced on them, the younger generation of women has much more access to maternal care information and more and varied medical support than the older generations. While this additional information and service has its advantages, on the one hand, they also have very mixed feelings about how to evaluate its merits and benefits in the Mi'kmaw context, especially in determining how to manage information from traditional and western sources that is contradictory in its advice.

Traditional knowledge on maternal health is passed down from female to female, and it is a rare occasion that a male could step into the female realm to speak about maternal health. Maternal health knowledge has been passed down from mother to daughter or grandmother to granddaughter, or aunt to niece, as these are considered the appropriate venues of the passing of traditional knowledge within the woman's realm. The older female members of families provided the standards of traditional knowledge

among the participants where they were offered advice on how to behave, what to eat, what to do or not do during pregnancy, how to give birth, and how to care for their new baby. This knowledge would be added to the already vast knowledge of childrearing from being groomed to care for others at an earlier age. Older girls were always expected to be in the care of younger others in the group, and depending on who was the oldest, each had responsibilities over others younger than them. Women were reminded often of traditional practices that they were expected to follow such as “not making noise during delivery” so that the women would be informed and mentally prepared before the event.

Beyond the child birthing experience itself, I was most interested in asking my participants if they had received any advice from their families, elders, or friends about their pregnancy, birthing, or after birth practices. This opened space for the women to speak to what was traditionally passed down to them, without putting pressure on them to remember specific knowledge. Most of the women were able to go deeper into what they heard and what they were told by elders about maternal health. Some participants needed more probing about their beliefs and what might be called ‘mythology’ about maternal health to uncover what they understood from their traditional beliefs. The stories provided the rich data that helped me to identify themes, which were put in the maternal health medicine wheel categories.

Participant Description

I categorized my participants from the study firstly into age groups: (1) Twenties (20-29) (2) Middle-Age (30-50) (3) Elders (60 +). I chose the age groups based on the participants ages, the elder group was sixty plus as many of my elders were in their sixties. I used the word ‘Elders’ not only to indicate age but also to indicate that the woman are respected members of the community, and knowledgeable in the area of maternal health. I start here by giving a brief description of participants in the twenties category range from 22-29 with young children. There were four women within the twenties category. Participants in the middle age range from 32 to late 40’s now have children whose age ranges from newborn to late teens. In this category, there were six women. The last category is elders. These four women were over age 50 and have adult

children and often grandchildren. Each category offers an insight to the cultural and social environment in which they experienced pregnancy and childbirth, providing different perspectives on how culture and maternal health has changed. Table One lists some biographic information for the women involved in the individual interview. A more detailed biographic description follows. It is important to place each person's experience in their context and background as each has shaped the findings and the results of this study.

Brief Biographies of Participants (TABLE 1)

Pseudonym	Age Category	# Of children	Martial Status	Age of mother with 1 st child	Living Status at the birth of 1 st Child	Breast Feed 1 st child	Vaginal Birth Or C-section
Ivy	Elder	3	Widowed	23	Living with husband	No	Vaginal Birth
Rose	Elder	6	Married	18	Living with husband	No	Vaginal Birth
Lilly	Elder	4	Married	15	Living with parents	No	Vaginal Birth
Violet	Middle-aged	5 (twins)	Married	21	Living with parents	Yes	Vaginal Birth
Daisy	Middle-aged	2	Married	23	Living with husband	Yes	C-Section
April	Twenties	2 (twins)	Married	20	Living alone in apartment	Yes	Vaginal Birth
May	Twenties	2	Single	18	Living with parents	Yes	Vaginal Birth
June	Twenties	2	Common Law	21	Living in trailer with partner	Yes	C-section

Ivy is an older widowed woman with three children, who is currently living on-reserve but when pregnant was living away from the reserve and gave birth while living in a metropolitan city. She was born and raised in her early childhood years on the First Nations reserve, until she came of school age and then attended residential school for four years. She raised her children in the United States, and returned to the Cape Breton reserve in her early 50's. She has had medical problems associated with her back as a result of birthing her last two children.

Rose is a recognized Elder in the community, married, having birthed six children and raised a few of her grandchildren and other community children, informally. She was married during her teen years, which was a norm in the community at that time, and had first child at age 18. She lived on reserve with her husband during her pregnancies and raised children mostly on reserve, although she also spent some time in a metropolitan city with her family. She did not attend residential school. Her mother died when she was a young girl and she lived with her aunt who had a very traditional Mi'kmaw background of working with medicinal plants and herbs. This traditional Mi'kmaw midwife greatly influenced Rose's upbringing and advised her during pregnancy. While a midwife was available, she gave birth at near-by hospital, where she had all vaginal births.

Lily is an older married woman who gave birth during her teen years to four children, two of whom survived, and two of whom have since passed: one died immediately after birth, and one other child died of a heart problem in her toddler years. She lived on reserve with her extended family in Cape Breton during pregnancy and gave birth at a near-by hospital. Both births were difficult for her, complicated by high blood pressure. She was hospitalized for two to three months after all her children were born. She reported having very poor health during and after her pregnancies. Without consent, she was medically sterilized with the last child after the birth while still under anesthesia.

Violet is a married middle-aged woman who gave birth to five children, and among them had one multiple birth. She was living on reserve during her pregnancies and gave birth at a near-by hospital. She accessed most of her maternal health in her home reserve in Cape Breton. She had problems with vaginal varicose veins with her last three children. She had all vaginal births and had medical problems only after having a multiple birth.

Daisy is a married middle-aged woman who gave birth to two children at a near-by hospital. She was in her early twenties living on reserve during her first pregnancy, although she was raised in a metropolitan city. She has accessed off-reserve maternal health services. With her last child, she had problems with her pregnancy that sent her to bed rest at the hospital during her last trimester. She had a vaginal birth with her first and a caesarian section birth with the second.

April is a young married woman whose first pregnancy yielded a multiple birth of twins. She was raised both on and off reserve. She was living on reserve during pregnancy and gave birth in near-by hospital. She received most her maternal health off reserve with the care of a family physician. Her first pregnancy with the twins occurred in her early 20's and she had a great deal of prenatal screening due to the multiple births. She experienced Toxemia late in her pregnancy, but had a vaginal birth with her twins.

May is a single woman who gave birth to two children, one while she was in her late teens and another in her mid-twenties. She had been living on reserve with extended family during pregnancy and gave birth in a near by hospital. In her pregnancy with her second child, she had problems with bleeding in the first trimester and had been told of the possibility of having a child with Down syndrome. She also had thyroid problems during both her pregnancies. She has had vaginal births for both births.

June is a young woman who gave birth to two children, while living on reserve with her partner during her pregnancies. She had her first child when she was in her early

twenties. She sought maternal health outside of the reserve setting to maintain her privacy during pregnancy. She gave birth at a near-by hospital. Despite having problems with high blood pressure and stress during both her pregnancies, she had vaginal births without any interventions or medications with both her children.

Focus Group Participants: There were six female participants in the focus group ranging in age from early twenties to elder women. There were no overlap between focus group participants and the individual interviews participants. All of the women were raised on reserve and had their children while living on reserve. The women all had more than one child at the time of the interview. There were more participants within the middle-age category, who had teenaged daughters who became pregnant during the course of the study. There were many varied experiences of maternal health amongst them. Focus group participants are identified numerically to protect confidentiality. Table two provides some demographic descriptors for each.

Brief Biographies of participants in Focus Group (TABLE 2)

Code for Focus Group	Age Category	# Of children	Marital Status	Age of mother 1 st child	Living Status with 1 st Child	Breast feed 1 st child	Vaginal Birth Or C-section
FG-1	Twenties	2	Common Law	20	Living with partner	No	Vaginal Birth & C-section
FG-2	Middle Aged	7	Common Law	15	Living with parents	No	Vaginal Birth
FG-3	Middle Aged	6	Single	17	Living with parents	No	Vaginal Birth
FG-4	Middle Aged	3	Common Law	18	Living with parents	No	Vaginal Birth & C-section
FG-5	Middle Aged	4	Divorced	Grade 9	Living with Father	Yes	Vaginal Birth
FG-6	Elder	5	Married	16	Living with parents	No	Vaginal Birth

Discussion of the Themes created from the Medicine Wheel Teachings

The medicine wheel framework provides an Indigenous perspective of the pregnancy and childbirth experience for Mi'kmaw women. The results are therefore presented by quadrant, beginning on the top right with the physical quadrant. This quadrant encompasses relationship building, caring for, responding to, and teaching builds between mother and child in the physical world. Results in this quadrant also include the nurturing aspect of feeding the baby. The second section is the emotional quadrant and explains when most women make the most significant emotional connection with their children. The spiritual world and the physical world come in contact with the mother, when they feel their child in their womb. It is a precious and emotional moment in the mother's life. Once the birthing is complete, the mother has time with her child within the safe and nurturing extended family and physical world. Mothers begin the bonding process with their children during this time as the emotional pull to be close and protecting of their newborn baby grows. The third section, the spiritual quadrant guides the woman to begin to accept the changes of consciousness of the two dimensions of their being, the physical and the spiritual. Last section, is the Mental/Intellectual Quadrant, which represents the stages of learning when teachings, readings, and advice from elders begin. The results will weave both western teachings and practices of pregnancy and childbirth with traditional knowledge, teachings, and belief systems of the Mi'kmaq. The medicine wheel thus allows for this research to explain maternal health experiences of women, while also exploring First Nations women's perceptions, attitudes, values and beliefs.

All the participants from this study described their maternal health stories in such a way that the medicine wheel model of analysis seemed natural. Each participant touched on all the quadrants of the medicine wheel during the interviews. In this analysis, I will be looking at four life cycles in the women's lives that directly relate to their maternal health. The four cycles are as follows: 1. Becoming a woman 2. Pregnancy 3. Birthing 4. Post Natal/Infant Health. Each of these life cycles will be examined using the medicine wheel, as each life cycle experiences can be further categorized into mental, spiritual, emotional, and physical. The undercurrent of the themes is to consider how Mi'kmaw women have experienced maternal health knowledge and how these have been

incorporated in their maternal experiences. In each life cycle, there will be stories that relate to all quadrants of the medicine wheel. The analysis that is being conducted in this chapter will be looking at these four life cycles and how the medicine wheel shaped each. To further illustrate this methodology, a graph below offers examples of four medicine wheel quadrants and within each quadrant a life stage is identified, which is also categorized into four quadrants. Each theme has combined these two medicine wheels to create a roadmap of the findings.

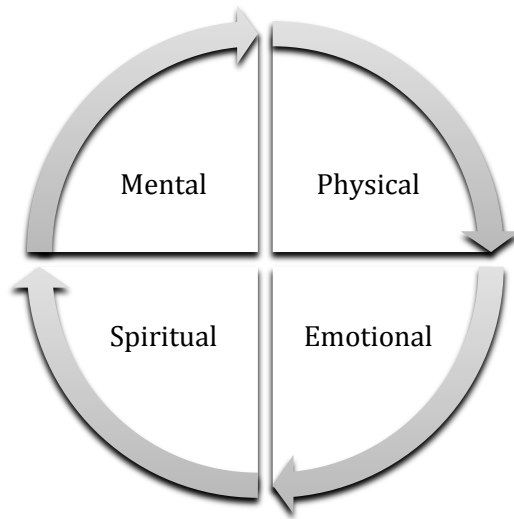


Figure 2. Human Wholeness Wheel

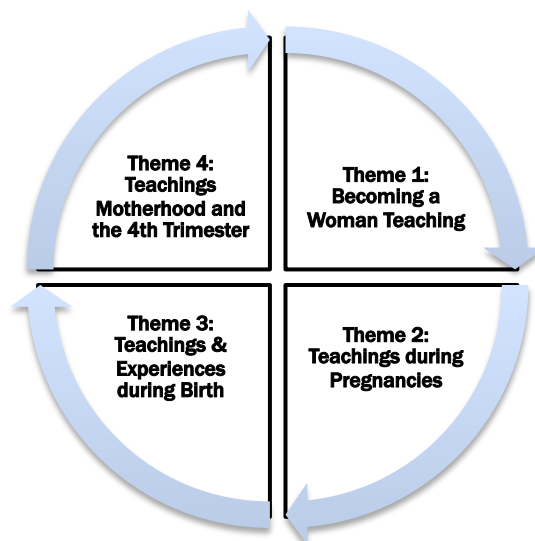


Figure 3. Maternal Health Life Cycle Themes

THEME 1: Teachings of Becoming a Woman in First Nations Culture

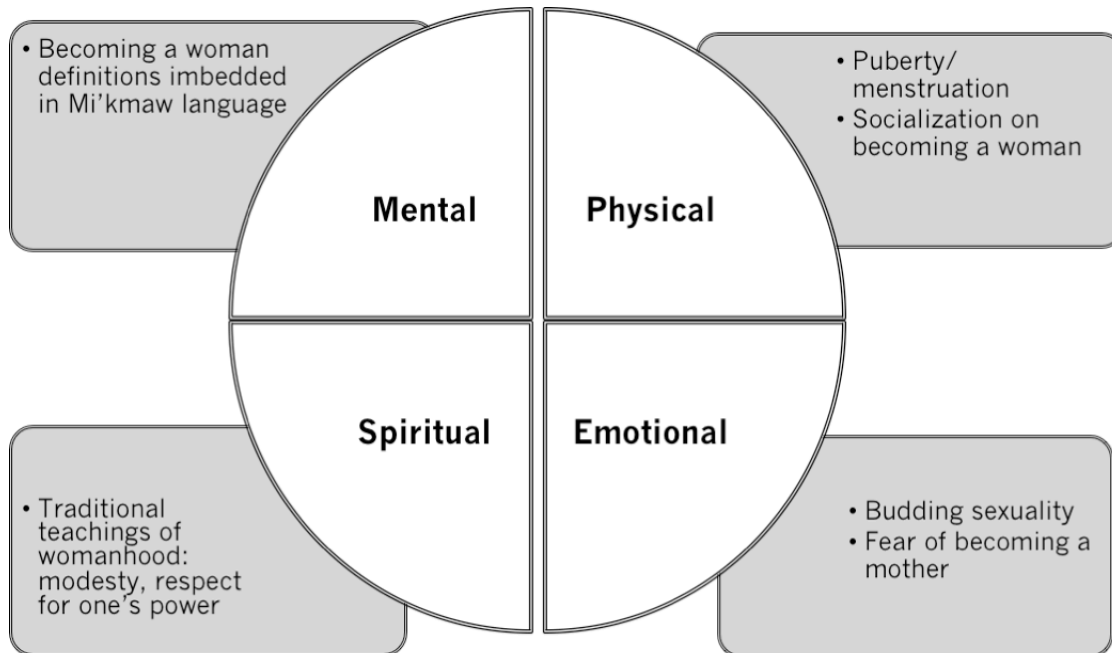


Figure 5: Theme One Medicine Wheel Roadmap: Teachings of Becoming a Woman in First Nations Culture

Background on Traditional Roles of Mi'kmaq Families

The traditional and contemporary role of Mi'kmaw woman is to be the keepers of the past and the future. “As life givers, women bring the children into the world, and for this they have traditionally commanded a great deal of respect” (Anderson⁹⁰, p.164). Mi'kmaw women are often referred to as the ‘fire keepers of the communities’. In early writings and by oral tradition, women had professional lives such as midwives, medicine women and basket makers^{91, 92}. They kept the society running smoothly by offering their learned and specialized and often unique services as ‘Elders’ to their families and communities, always respected teachers and guides for nurturing children in the society¹⁴.

The roles of men were to be the keepers of the present, providers and protectors of the society⁹⁰. These male roles were held to keep the women, elders and children safe within the family circle. These roles were taught through life long experience and exposure to community, to nature, and to traditional teachings.

While many of these teachings remain to the present, Indigenous knowledge and its teachings have been impacted by the introduction of English language, white colonial society, and Eurocentrism to First Nations people. The First Nations men were the first in contact with colonists and were the first to be attacked through their traditional roles from settlers. Settlers sought out First Nations men for their own sustenance and protection when they arrived in “Mi’kma’kik” and for negotiating for their space on the land as they presumed the Mi’kmaw male roles were similar to those in colonial society. First Nations men were then either attacked or appeased with alcohol and imported foods, thus yielding to new diseases, including alcoholism, diabetes, cancer and other health problems which also caused the disharmony and relational breaks in the protective circle around women, elders and children¹⁰. As the roles of a traditional society began to change, First Nations culture started to show signs of breakage in family roles⁹⁰. What modern Mi’kmaw people experience today is loosely connected to the traditional laws and behaviors of the people, holding strong to relational values of family, connections to land, spirituality, albeit Catholic, and strong respect for Elders. The remainders of these traditional family roles have been negatively affected over the last four centuries since Mi’kmaq have experienced colonial contact.

Physical Quadrant:

For Mi’kmaw women, the teachings of becoming a woman start long before one reaches puberty. Women’s roles are socialized in a variety of ways, such as modeling, storytelling, and specific cultural teachings during key life stages. Traditionally young women would attend moon ceremonies to “receive teachings: this is where they would hear the sex education and the parenting skills and the basic life skills. How to care of themselves and to respect themselves as women (sic)” (Anderson⁹⁰, p. 166). In Mi’kmaw First Nations culture, most young women believe that their menstrual cycle dictates the beginning of their entrance into becoming women, privileging them to move from being

in the child circle to joining the women's circle. The onset of puberty can also be seen as a key marker into the women's circle. Physical manifestations of changing into a woman from a child happen to a person gradually, which include hormonal changes, body changes, emotional maturity, and the ability to reproduce. In the past, during their early teens, young women would also be preparing to take a husband and to managing a household. Today, however, Mi'kmaw culture continues to change in values related to when they take partners, have children, and enter marriage. Some elderly women in the study were married in their teen years, while the middle-aged women in the study were pregnant before or during their marriage and the younger women in this study are currently unmarried but with children.

Physical markers of fertility have helped socialize women into their societal roles since the beginning of time. Being able to birth a child has been the center of women's strength in First Nations communities, for the survival of the culture depends on women's reproduction and their ability to maintain a continual healthy population by the adherence to their helpful teachings of maternal health practices. Children are widely accepted and valued despite the age of the mother for they ensure the survival of nation and the traditional practices and teachings ensure the survival of culture, language, and belief systems. Thus it is no wonder that women have been socialized to believe that becoming a mother is one of the most important aspects of a woman's life.

Many elders continue to put all of a woman's worth in her ability to nurture, care for, and produce children within First Nations communities. As a young teen, I often heard elders speak about having children, and was often asked when I will have my children. In the interviews, one elder talked about how her generation worried about how long a woman remained childless, where someone in her twenties without children was frowned upon as the older one got, the more likely one might have difficulties. Since I am twenty-nine years old now, and still childless, they often express their sad feelings for me that I have not achieved this ultimate goal for women. Their strong teachings of having children early have contributed to my believing that motherhood is an ultimate goal in life and one is not complete without children. While understanding their fears and beliefs, I have chosen education over motherhood for the time being. However I have come to realize that being resistant to this ideal of motherhood is to be almost taboo within a

culture that prizes children above all. In a culture, where children would take care of parents, as they became elders, the people prized that the good treatment of the young would result in good treatment as parents toward their children and also to their elders.

The introduction of Mi'kmaw women into the physical quadrant of the maternal health medicine wheel begins at puberty. Girls often start their menstruation in their early teens. This is a time that is marked by physical changes from being a girl child to a woman, and is often followed with lessons of morality and life teachings about becoming a mother. One of the elder women participants Ivy, spoke about their own experience with having their first menstruation and how it was shrouded in secrecy within the women's realm and the confusion of how this physical process occurs. This elder participant had attended residential school and was not taught about anatomy:

Ivy: "every time she {her mother} tried talking to me about it {puberty}, I couldn't understand how a woman could bleed from down there for no reason"

The imposed values from residential schools⁹³ had affected how Ivy understood her own body processes and created a disconnection of traditional teachings from mother to daughter. Residential school often negatively affected women as they had no one to turn to in the schools that could share that knowledge with them and fear and shame became connected to menstrual cycles until they learned from older girls about what was going on. A girl's process of entrance into womanhood was often only introduced at the first signs of puberty when a woman (mother/aunt/grandmother) would assist her and offer her knowledge about this event. Many of the participants spoke about the privacy that shadowed this event and how it was kept from men in the community. This significant event would also mark the introduction of women's maternal health knowledge, as they would begin their teachings on motherhood and upcoming events of womanhood. The next time they spoke about their physical growth and changes begin at the onset of their first pregnancies.

Emotional Quadrant:

In learning to become a woman, the emotional quadrant situates a woman learning about her experiences through her emotions, instincts, and feelings. Many of the women expressed a great variety of emotions when discussing becoming a woman.

Elders spoke about the how their sexuality and talk about it were denied in their upbringing and talk about womanhood only included their behaviors, actions, and future expectations. Future expectations of being a mother or doing domestic work in the home were ingrained in traditional teachings and from modeling from elders in the more traditional communities, to governing or managing male-female relationships and behaviors of the younger generations. These expectations would include religious teachings yielding to Catholic beliefs and values about marriage, baptism, and church attendance. Thus becoming sexually active, without being married, caused the participants a great deal of emotional distress, as they knew that these were the expectations created by the Catholic Church in particular, they remain chaste and virginal, despite the fact that in earlier traditional times it was expected that a young man would have to live with a young women's family to show his abilities to care for and survive within a family setting⁹⁴. Four hundred years of Christianity has had its impact on Mi'kmaw people, particularly on issues of male-female relationships and ceremonies marking major family events. Thus becoming pregnant was evidence of young people practicing a social taboo in the Christian religion but was commonplace and accepted in earlier times when the people practiced traditional spirituality. The women had to walk a fine line between what was taught at residential schools (where sex and menses was often viewed as shameful and treated with abhorrence)⁹⁵ and at church, and the traditional practices that allowed for sexual activity without shame. The women in the study negotiated their personal paths, between what was imposed on them by the Church, how their parents treated those expectations, and what they believed in their hearts, as sexual activity is seen as a part of relationship building with a partner and holds a key to the emotional bond of love between partners.

Beyond relationships with the women's partners, many of the participants spoke about their feelings of worry and anxiety about their changing roles once pregnant. Some elder participants spoke about fear, as they were unsure of what becoming a mother and a provider would involve, and the sacrifices and changes in lifestyle that would eventually occur. Almost all generations spoke about the apprehension of becoming or being an unwed mother and had experienced both terror and trauma about when telling their parents or guardians about an unplanned unwed pregnancy. The relationships between the

participants and their parents, often was spoken about as the pregnancy was revealed to close members of the family. Some participants noted the expected or unexpected reaction of parents to pregnancy, which had affected their own feelings about themselves and their pregnancy. Many of the participants spoke about the hiding of their pregnancies, and about the fear of becoming mothers and letting others know about their changing status. These were common sentiments among all participants, the concern of not living up to traditional, family, community and societal standards of Christian beliefs and motherhood. The emotion quadrant allowed women to speak about their stresses, anxiety, and fears about being women and becoming a part of the women's circle as well as becoming a mother.

Spiritual Quadrant:

Women's roles in Mi'kmaw culture are intertwined with the expectations of becoming a mother, a provider, a nurturer, and a teacher. Women are prepared on a spiritual level for their female roles, as they are expected to become the teachers of spirituality in the community and thus are often taught about morals of the society in which they are raised. The women within modern Mi'kmaw cultures are taught a mixture of Mi'kmaw values and Christian values. Females are taught that their bodies are sacred part of life and should be treated carefully because they hold a great deal of power. Young women are told that once the egg is fertilized, they become sacred ground and must be careful not to offend the spirit world. One of the traditional teachings amongst the Mi'kmaw from my upbringing is that women are never allowed to walk over a man's feet as it diminishes his power and shows disrespect. She is to find a path at all costs away from crossing in front of men. Women's menstrual blood has also to be treated carefully, especially around men's activities. Women on their menses are not allowed to be around drums and weapons or to touch eagle feathers. These are some of the teachings of my youth, even before the subject of motherhood arose. These teachings taught how sacred and powerful one's womb and menstrual cycle are within the First Nations culture and more specifically Mi'kmaw culture. These teachings lay the groundwork for women's roles and teachings.

Modesty is a major virtue in Mi'kmaw society, and while it has been reinforced by Christian belief systems, it was evident long before the missionaries introduced Catholic beliefs as noted by Father Christian LeClerq in 1691: "[the gaspesian people show] much more modesty than does this false deity [Hercules], as shown in particular care which they take to cover and conceal that which nature and decency do not permit to be shown" (Ganong⁹⁶, p. 93). Many of the women in my research speak about the importance of being modest around men, during their pregnancy and afterwards. Embarrassment about breastfeeding openly from my participants can be attributed to this virtue of modesty surrounding the body. Today, this might be viewed as a socialized value that has a controlling influence on female sexuality within the confined spaces of Mi'kmaw communities.

Public displays of sexuality and sensuality or open signs of affection toward men or even partners are also often frowned upon¹⁹. The elders in the study spoke of their disapproval of women wearing tight clothing during pregnancy, not just as an issue of affecting the baby but also for showing one's body openly to others. Showing one's cleavage, bum crack or belly is also seen as being immodest and disrespectful to one's elders and to the men in the community. The modest virtue and many other virtues are often taught during early womanhood to help maintain social control and order. With the influence and availability of modern pop culture by television, computers, movies, newspapers and magazines, however, many of these virtues are changing within Mi'kmaw society, to the distress of many elders and mothers.

Mental/Intellectual Quadrant:

As girls begin to learn about womanhood, there is an undeniable value towards motherhood, and the cultural privileges that accompany being in the women's realm. To reflect on these cultural privileges, I share a personal event when I was a teen when an elder woman at a social event, told me that without a child, I would remain a "e'pite's"⁹⁷ or in English a "young/unmarried woman," but my friend of a similar age who already had a child is considered a "e'pit" or "woman". Therefore my friend was allowed to sit at the "women's" table and listen in on women's discussions. I would always be sitting with

the “children’s” table taking care of other women’s children until I gain entry into the “women’s” table. Thus from this experience I learned about the status and prestige that is gained through pregnancy in the community, as a girl, regardless of age, once she has birthed a baby, is considered a ‘woman’, and thus can enjoy benefits as in the role of “e’pit”/women which is qualitatively different from those who are “e’pite’s”/young woman. “E’pit”/women realm offers privileged knowledge and insider stories to which an “e’pite’s”/young woman would not be exposed. My status in the community is uniquely positioned of still being considered a young woman, not yet a woman until I am married or have children, but the maternal health stories that elders shared with me could be considered beyond what my status would be allowed normally to have in the social context. Even within the Mi’kmaq language, there is a word that means that one is “becoming a woman, or entering womanhood” which is “e’pite’su’et”⁹⁸. The other distinctive roles of woman can be witnessed in the expectations of behaviors and duties during community events such as death of members of the community, cleaning their house, the body, wakes, ceremonial gatherings, and in general family life. Embedded in our Mi’kmaq language are the ages and stages of life, marked by language, roles, responsibilities, different knowledge systems and different status within the community. Thus it is a cultural value that a girl should strive to climb the “matriarchal” status hierarchy from “e’pite’s” position to “e’pit” position to eventually become female elder and head of the family, in Mi’kmaq “kisikui’sqw”, and one way of completing this task is to become a mother.

THEME 2: Maternal Health Teachings and Experiences during Pregnancy

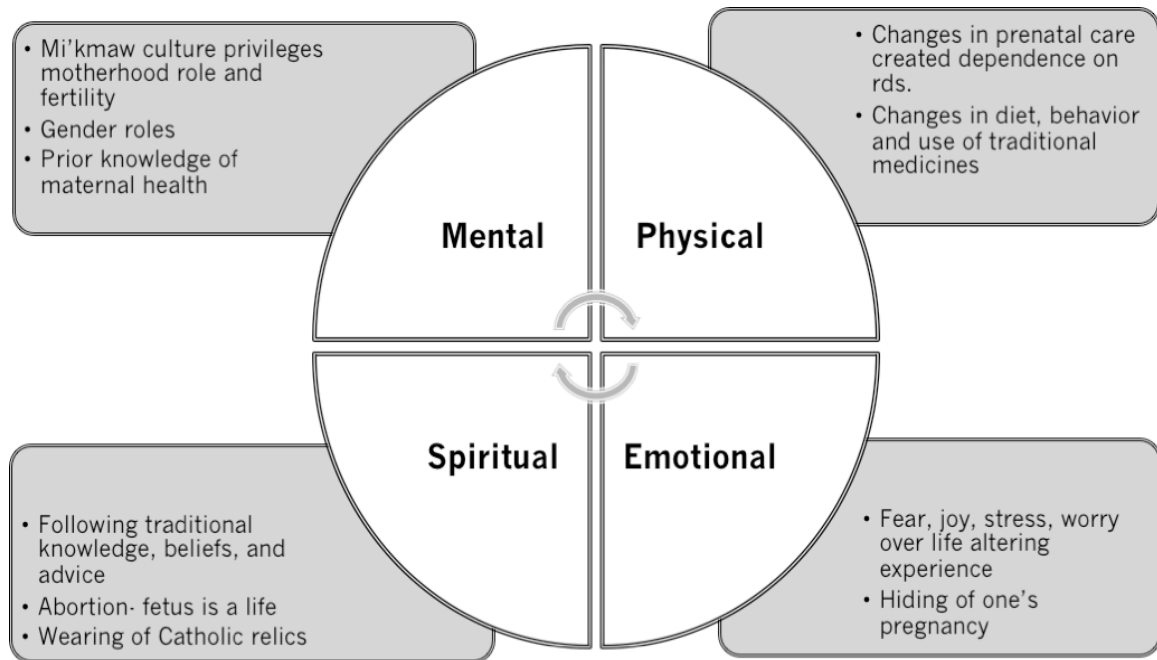


Figure 6: Theme Two Medicine Wheel Roadmap: Maternal Health Teachings and Experiences during Pregnancy

Background on Participants During Pregnancy

All the participants had become mothers as young adults. For all the women, the ages when they had their first child was between 15 and 23 years of age. The average age of having their first child was approximately 19 years old. Aboriginal women in Nova Scotia were observed as having higher teen pregnancy rates than non-Aboriginal women⁹⁹. The four elder participants noted that in their days of growing up, having children young was to be expected, and that most women were married by the age of 18. However, the elders also noted that the younger generations today should not be having children as early as they are having them, as there are more opportunities given to the youth today to be educated and employed. Elders thought that education was important and one should wait until after they were done high school before having their first child. The elders also lamented on how many of the mothers of the present generation are often

raising their children on their own with little help from the fathers. Since most elders were married at a young age, they had husbands and extended close-knit families to support them. The elders pointed out that current society is much more reliant on social welfare to provide for their children. However, aside from the elder's advice, many of the participants had their children during their teens, and most all were still obtaining some form of education at the time of conception.

The current attitudes and values of the Mi'kmaq support the value of sexuality as a normal and natural act. Being chaste and remaining a virgin until a woman is married has been a Eurocentric value that has been imposed on Mi'kmaq people. Historically having children out of wedlock did not hold the same social stigma as it does in European cultures, rather "because of their proven fertility, in some cases single women with children were especially prized by men seeking wives"(Paul¹⁹, p. 24). The values of the church have been imposed on Mi'kmaq women; however, this has not altered over time their behaviors. All the younger participants and a few elders were unmarried at conception of their first child, which led to an undercurrent of Catholic guilt in their narratives, and often led to a period of hiding pregnancies to the public.

Physical Quadrant:

Prenatal screenings within the First Nations Community has changed greatly over the last 40 years. Elders from the community noted how they rarely saw doctors or nurses in their pregnancies. In this regard, one elder from the focus group noted:

F-6: "yea they didn't check you very much, you went to your own doctor, he only checks you, but there like was no prenatal care, or someone coming in showing how to take care of your baby, or offering you stuff or they don't do that, they didn't do that."

From not having doctors within the community at all in the early 1950's, Mi'kmaq women have seen major changes from having to rely solely on the local Mi'kmaq midwife to monitor pregnant women and help with delivery to the present day modern health center in the community that is staffed by family doctors and nurses who monitor pregnant women and assist in their deliveries at local hospitals. Up until the 1970's within the communities, Mi'kmaq had only midwives who addressed all of the women's

maternal health knowledge and the gaps of knowledge that were not generally accessible to Mi'kmaw women. Women before the 1950's were comfortable in using local midwives to conduct home births, as transportation to the nearest hospital was difficult due to poverty and the lack of modes of transportation. Elders from the communities noted that hospital births have been a colonization of traditional midwifery practices as they pushed traditional midwives out of practice to favor western medical practices regardless of their practicality. Hospital births gained precedence as fear was instilled in pregnant mothers about possible complications in delivery, and birthing was assumed to be a process requiring medical intervention and sometimes needing advanced technology⁵⁷.

At one time, the elders were dependent on the family doctors that worked within the First Nations communities in makeshift health clinics. One family doctor stands out as one who remained in the community for over 40 years and delivered most of the children from the various surrounding Mi'kmaq First Nations reserves from 1960's to 2000. Since this doctor's retirement, however, and the loss due to the erosion of Mi'kmaw midwifery in the community, many of the younger women were powerless to have control, choice, or continuity of care in their prenatal screening. Rotating doctors have now caused women to not have a consistent family physician and they are often at loss at who will be delivering their child. Women are currently lacking the personalized care and relationship building that comes with having a midwife or even a consistent family physician.

Many of the younger women participants today who live in First Nations communities have never had a regular consistent family physician. Each named around four to five different doctors who did their prenatal screenings and delivery. Violet, a middle-aged participant, with five children noted: *"I have [sic] different doctor every time I delivered"*. One of the participants in her twenties, April, chose not to access health care on the First Nations reserves, so that she could have the same family doctor from her childhood. April noted how consistency made a difference in her comfort level: *"He was my doctor all my life and he's my doctor during my entire pregnancy."* April found that she had a greater amount of care than most women get at First Nations clinics: *"I was going to the doctor every week, going for stress tests and every week, and at the*

very end, the last month, I went every week for an ultrasound". April felt that she was getting good health care due to the additional attention she received by her health care provider. Another younger participant, June, chose to go to childhood family doctor who worked off reserve, as a means to hide her pregnancy from the members of her community.

June: "I was going to see [an old FAMILY DOCTOR] in [URBAN HOSPITAL], I didn't go to the prenatal clinic here [reserve health center]. Cause I didn't want anybody to find out, and I didn't want anybody to know I was pregnant... so I would go there, its like a hour and half drive, so I could go see him, plus he delivered me, I wanted him to deliver my baby, I was comfortable with him and everything."

This participant received prenatal care off reserve, being in the privileged position to have her own independence with her own car and the means to afford to go for prenatal care far away from the community where she lived. June's position was a privileged one, in the sense that many are unable to exercise this option due to poverty and lack of transportation. Only three out of six younger participants were able to control their health care during pregnancy, and access a doctor with whom they felt comfortable, and with whom they had an established patient-doctor relationship. All the other participants spoke about not having control over which doctors saw them during their maternal health screenings and delivery.

The women who spoke about lack of control over their doctors during delivery said that they felt powerless to change their situations. One participant, Daisy, noted she was promised by her family doctor that he would deliver her child, but then the on-call doctor told her that he was not going to call the family doctor because he was the physician on-call that particular night.

Daisy: "he [on call doctor] was kind of pushy, I wasn't pleased, I said I don't want you near me, call Dr. [family doctor] back from Cape Smokey, and he [on call doctor] said, no I'm on call, I'm going to deliver your baby, I was really unhappy with him, I didn't like him at all at that point."

During the focus group, one middle-age participant told the younger participant who complained about her nurses during her deliveries, "F-2: when you're having a baby, why bother asking, who fricking cares, they [the doctors/nurses] are going to do what they do". In essence she was telling the young mothers that Mi'kmaw women have no control over their health care, as in her experience, the doctors don't listen to the women, and do

whatever they want regardless of the mother's requests. This disempowerment of health care, located at a system level, shows the gap between the participants' ability to control their circumstances and physicians during pregnancy.

Another point the participants spoke about in the physical quadrant was the change they experienced with their behavior that was culturally and socially imposed on them due to pregnancy. The physical changes are only a part of the upcoming changes that a woman has to handle to prepare for her baby. The mothers in the study spoke about how they started to change in the way they acted with their behaviors matching Mi'kmaw protocol and society expectations. The participants had to reconsider engaging in taboo behavior such as smoking or drinking. They also had to change their diets and activity levels. Many of the participants spoke about adjusting their behaviors due to their pregnancies and being socially monitored by members of their families. Some of the participants noted that changes in diet were often based on cravings, and creating a healthier diet for ease during breastfeeding. Some of the advice from elders regarding food and breastfeeding were as follows: do not eat turnips, broccoli, apples, chocolate, and carbonated beverages, as all these food items tend to create gassy distressed babies.

Diet was a means of gaining health for the new mother and the baby, and thus was controlled by the new mother and the family members who surrounded her. Often advice was given on what were 'good' and 'bad' for the baby, regardless of the mother's personal taste preferences. The social aspect of monitoring behavior and diet are ways that a community helps contribute to maternal health care by offering often-unsolicited advice and traditional knowledge to a new mother.

The participants also noted that food was a means of healing and health in their maternal health. Some women altered their diet to cure ailments that was associated with their pregnancies such as warm milk to help one sleep, or oranges to help with constipation. The participants noted they used traditional medicine as preventive or curative in their pregnancies. The most common use of traditional medicinal knowledge was cranberry juice to prevent or treat bladder infections. One participant used what is called in English 'elder tree bark' or in Mi'kmaq "tupsi" for the purpose of treating migraines. Another participant was given a handful of "Crowberry's" to eat, which is a small bitter red berry found in low laying ground shrubs, which are thought to prevent

illness during pregnancy by the Mi'kmaq. One participant was told to eat liver to prevent migraines and to build up her blood for delivery. These uses of traditional knowledge and the healing properties of food allowed Mi'kmaq women ways to heal themselves of common ailments during pregnancies. These traditional knowledge systems have been passed down through the generations and have been used to advise new Mi'kmaw mothers.

Emotional Quadrant:

The life altering moment of confirming one's pregnancy was very vivid for participants, filled with expressions of grief, happiness, and fear individually and all at the same time. One mother, April, focused on her fear of losing the child and chose not to tell anyone other than her boyfriend until the first trimester was over. June was fearful of her parents' reaction, and chose to keep her pregnancy a secret until the third trimester. Many of the women expressed shock over the news of their pregnancy, whether they were young or old, married or single. The experiences of finding out they were pregnant commonly brought both joy and fear into the participant's hearts.

Ivy: "[the doctor] examined me, and says you're pregnant, I almost cried, I'm like I'm not, I can't be pregnant, and he goes, you're pregnant, I was like... oh my god I'm just a baby, and I was scared! Cause my friends all had babies and I loved their babies, but I just adored their babies but me having a baby, no. No. We were having too much fun, never stayed home, never cook, like mom says I didn't know how to cook, I never had to cook, the minute he got home, boom we were on the go. We lived like a single life, having a ball."

Life is altered for many of the participants once they became pregnant, and even further when the pregnancy is announced to the family, and the community. One participant spoke about how pregnancy was dealt differently within the 1950's amongst Mi'kmaw women:

*Rose: "cause in my days, no one mention pregnancy, it was very hush-hush, until it happened to me, when I became pregnant and the whole world seem to change, for me, it changed for me, although it changed I saw the physical change myself, but there was other things that were imposed on me, in fear of the baby health and spirituality, which I wanted to do cause I don't want no harm, come to my child. It was different, um for instance, when I announced that I was having a baby, all the old ladies were all growling *MI'KMAW - (you must take care of yourself)"*

The elder spoke about how women were not supposed to broadcast their pregnancy as it was something that was dealt with primarily within the women's circles. Traditional knowledge transfer between women began as soon as a woman admitted her 'condition'. Rose received advice immediately after telling her family about how to treat oneself during pregnancy. The 'old ladies' were there to speak to the young mother-to-be about what responsibilities she will have to take on and about how she must take care of the mental, spiritual, emotional, and physical health of her child, in the womb and out in the world. The announcement of the pregnancy was a key life transition point, and once the 'old ladies' became aware, it was a time of teaching and caring for the new mother-to-be in a sacred way. Pregnancy was seen as a very blessed and sacred time as she straddled between her traditional beliefs and those western beliefs regarding maternal health.

Pregnancy was often not broadcasted amongst the Mi'kmaw women in the past, and would seem to continue in the same way today. Almost all the women in this study hid their pregnancy for a period of time, and all for different reasons. Some of the participants were fearful of their parents reactions, others were fearful of losing their babies, and some chose not to tell anyone until the baby was born. Some younger participants were afraid of the reactions of others, due to being a younger mom. Oddly enough, most of the Mi'kmaw women in the past, prior to contact with settlers, were married and had children in their teens rather than in their twenties. Younger participants spoke about the Catholic ideology about 'being a young unwed mothers' that is considered to be a sin. The effects of residential schools teachings on sexuality influenced young women's feelings of unease about disclosing pregnancy since they would then be exposed as having engaged in premarital sex. Even married couples chose to keep their pregnancies from members of the community for a short period of time as well.

Ivy: "today when they {new mothers-to-be} are pregnant they wear tight clothes. I had all three of mine, and nobody knew I was pregnant... I wouldn't wear maternity clothes. I bought bigger and bigger clothes cause I didn't want anyone to know I was pregnant"

Lilly: "I didn't tell anybody and I didn't tell my parents... um I think I must have been, 6 months pregnant, when they knew."

June: “Everybody was asking me... are you pregnant cause I was pale and my nose was kind of big, and I was like no, but I was super pregnant, I was just scared of my dad and my mom, I was like I just didn’t want anyone to know”

FG-3: “yea, well I hid my pregnancy from my family for 8 months”

FG-6: “I don’t know, they all look at you funny, especially when you’re a teen mom, looking at you funny, so I hid all my pregnancies”

It was often the fear of the parents’ reaction that kept the younger mother-to-be and her partner in fear of telling them of their pregnancy. Some waited until their last trimester to tell their parents about their pregnancy. One participant, June, was 21 and living with her boyfriend, and yet she still had fear over what the parents’ reaction may be as they were not supportive of a younger sister being pregnant at the same time. Another elderly participant, Ivy, chose to keep her pregnancy from neighbors and friends but told parents and family members. The consistency of secrecy around pregnancy was an unanticipated finding in this study, especially in light of the women simultaneously speaking of their pregnancy as a joyful event for themselves and their communities.

Spiritual Quadrant:

The importance of the spirituality in relation to the fetus/infant was enforced in many of discussions held with participants. The elderly participants spoke about their children, of their spirit speaking to them during pregnancy through dreams, in prayer, and intuition. Mi’kmaq tradition holds that the child has a spirit from conception and is aware of the events that are occurring around them. As one participant noted: “*to you it’s a fetus, to me it’s a baby*”. One elder participant, Rose, spoke to her child while still pregnant to inform her/him of the upcoming event and to remind the spirit to follow her wherever she went.

Rose: “You listen to those little tricks, but you don’t harm anyway, physically, and spiritually, you don’t tread on sacred grounds to satisfy your own physical needs, or visa versa... in fear of the babies’ health. Both physical and spiritual health”

This is an example of the spirit-body connection women have with their child during pregnancy. The child is thought to have a unique spirit in its being and a mind of its own.

This spirit is a link to Creator and to all the ancestors and an important emergence, as pregnancy is seen to be a spiritual and sacred journey for both mother and child.

A Mi'kmaw value that is involved in becoming a woman is that the egg fertilized at conception is considered a living being with the capability of having all the human emotions. Mi'kmaw women believe that God/Creator gave them children and that it is a spirit gift; therefore, it is not advisable to have an abortion. Abortion in the Catholic tradition is also forbidden, and after 400 years of Mi'kmaw Catholicism⁷², the Mi'kmaw people see abortion as also a taboo subject. However, while the infiltration of Catholic teachings has caused today's elders to side with the church on abortions, traditional teachings carry narratives about how it was possible to prevent births or terminate them. It was said by some elders that the old midwives were able to teach young women about controlling one's fertility and even had methods of using traditional medicines to cause abortions. Thus, traditionally Mi'kmaw women in history were well informed in controlling their fertility cycles and reproductive systems⁹⁰, which has allowed every child who entered the world to be wanted and properly cared for by the mother and father.

While taboo on the one hand, the topic of abortion emerged surprisingly often in interviews. This was the case even though I was careful not to ask any questions that I felt would lead to this discussion. The women spoke about abortion at the time of finding out about their pregnancy and doctors offering them "their options"; however, most women left either offended or distraught over the mention of an abortion. One younger participant did participate in an abortion but did not want to speak about it during the interview. An elderly participant, Lilly who had life threatening complications to her pregnancy felt that the doctor was killing her fetus on purpose in order for her to miscarry. The doctor, in that particular case, even consulted Lilly's parish priest and got approval from the bishop to perform an abortion. Lilly refused and felt that he tried to cause a miscarriage throughout her pregnancy by the use of strong drugs, resulting in her child dying shortly after birth.

Lilly: "yup he [the doctor] was killing my baby, he probably thought I would have a miscarriage before you know, because the drugs he gave me you wouldn't take those if you were pregnant, you wouldn't, doesn't matter who you are, and um he just giving me pills, pills, pills, cause my blood pressure was high, as soon I got

pregnant”

Another elderly participant, Ivy had a doctor that told the participant not to get pregnant due to her back issues, and then tried to convince her to abort once she got pregnant.

Ivy noted: *“I was told not to get pregnant but I did, I got pregnant, and they asked if I wanted an abortion, well abortion was completely out of the question”*. One younger participant, May had been told that she had the possibility of having a child with Down Syndrome and the doctors rushed her through ultrasounds and chromosome tests so that she could be under the twenty-four week abortion limit.

May: “I was far along when I went to the ultrasound, but I remember thinking that I was pro-choice and stuff like that, but after I saw the baby I didn’t think like that anymore, my life changed big time. I said well if the baby has Down Syndrome or anything, I will take it in stride, I can’t risk his life right now, so I didn’t go for the amniocentesis, and the reason they tell you that, is that some people they have an abortion if their baby is not up to their standards.”

May felt conflicted between a complex web of the traditional beliefs of conception and the Catholic Church and the feminist views of being “pro-choice” for abortion and the western medicine value systems that her doctors were imposing on her. May had to negotiate on her own personal core belief system and chose what she felt was best for her and her baby regardless of the advice of doctors, friends and family members. Another younger participant, June got pregnant before her child turned one and the doctor offered to tell her of her options, but June refused to listen to her ‘options’, as she did not believe in abortion. June left the office feeling offended and feeling remorseful for her living child to be losing out on being the baby of the family. All the participants had opinions on the topic of abortion, but the majority consensus was that it was out of the question even if it meant their lives were in danger due to religious reason or to cultural beliefs. The topic of abortion emphasized the Mi’kmaw value of motherhood, the belief in the life force of a fetus/baby, and blending of medicinal and traditional values in maternal health.

Another topic discussed by the participants was the use of Catholic religion icons during the pregnancy and birthing, which are commonplace among Mi’kmaw women. Many types of religious articles were considered important to my research participants. Most pregnant Mi’kmaw women were often offered these items from older woman, family members, and members of the church. They were told these items were important

to wear everyday of their pregnancy in order to protect them from difficult pregnancies. Some of the items used are Baby Jesus Medallion, Saint Gerard Medallion (patron saint of pregnancy), a knotted necklace (with three knots, one for you one for the baby and one for the umbilical cord), Saint Anne oil and Saint Anne water, Saint Anne medallion, and a Saint Anne cloth anklet that is given out during “Mniku”^{viii} ceremonies. Saint Anne is as important as is Saint Gerard, as Saint Anne is the patron saint of the Mi’kmaq, being the grandmother of Jesus, thus holding the highest esteemed position in Mi’kmaq society. St. Gerard is a patron saint of women who want to become pregnant. Religious items were used with almost all the participants as a means of protecting the mother and child, and also were indicators that announced a pregnancy for expecting mothers when it was atypical to announce publicly a pregnancy.

Mi’kmaw women were traditionally modest about their conditions as it was seen as being a part of life and nothing out of the ordinary. Pregnancy was to be discussed only with family members, and not publicly announced for a belief that boasting may have the effect of losing the child. Many of the elder participants were secretive about their pregnancies letting only few close female family members know about their condition. One participant told me that it was taboo to even mention your pregnancy in the presence of a male who was not your close relative. Being pregnant and getting advice from your relatives on your condition was seen as a private affair. These values have changed in present time, and the elders all noted the difference in the way pregnant women carry themselves in comparison to their earlier experiences. They assert that the wearing of religious articles or relics has been used as a semiotic to indicate pregnancy in the past and to indicate spiritual care for the child. Women typically start to wear relics about the second trimester, as they begin to show physically as well.

Many of the participants were told to use these relics as a means of connecting with the spirit and incorporating religion into their prenatal experiences. Some participants made a conscious effort to pray for their babies on a daily basis while others participated only half heartedly to appease their family. Some of the women hid their relics while others wore them openly over their clothing or as necklaces. Some of the

^{viii} Mniku is the Mi’kmaw word for the sacred meeting place that is on an island near the reserve of Chapel Island. People gather twice a year to celebrate the patron Saint Anne, and to conduct Grand Council meetings.

participants were unsure why they used relics during their pregnancy, only doing so because they were told it was important. The participants were partly afraid that if they did not participate that something may go wrong with the pregnancy and others would blame them for not following tradition, in a sense proving them right that relics do have a power to protect.

Daisy: “they were really big on blessing your belly, so, when my mother in law came back from Quebec, she had the necklace that I had to wear, and she had a little bottle of oil, umm, and she told me to rub a little on the belly each day to just kinda give the baby a blessing, I didn't do it. A little bit here and there, I figure the oil; you gotta oil your baby anyways to keep the stretch marks down, but no, that was pretty much it.”

June: “I...wore the Saint Anne Cloth, and I wore Saint Gerard and that cloth on my bra, and that white cloth... with knots on it... My godmother gave it, it had a sacred heart on it, and a Saint Gerard on it, and the knots on it”

Many of the younger participants took their relics into the delivery room with them. They noted that the hospital staffs were both courteous and respectful of their request to have these items on or near-by even during C-sections. Relics held a special comfort to the participants as they believed in their power to protect and save. One elder participant, Ivy, a residential school survivor, spoke very little about the religious part of her pregnancy except to say she prayed during labor asking God to not let the baby out causing her too much pain. The other two elderly women, Rose and Lilly spoke of wearing the St. Anne cloth or using St. Anne oil during labor. All the participants spoke about praying for a good outcome in labor and for the health of their children. Relics held an important aspect of their spiritual journey in their pregnancy and labor.

Mental/Intellectual Quadrant:

First Nations women have been socialized to the values that would inform their future roles as mothers and elders, and allowed for the young women to gain knowledge about teachings around pregnancy and motherhood. Mi'kmaw gender roles within the community are shaped within this quadrant, and for girls, it also teaches them how to prepare for one's major life event-- pregnancy and birthing. Pregnancy is a time when spiritual and intellectual teachings are more needed and present to help the mother adapt

to her new life and to take on the mothering role as a learner and future teacher. This learning cycle will happen with every pregnancy a woman has during her lifetime. Many of the participants noted they “already knew” about how to care for children, as it is a common value that the child of one is the child to all in a community setting. Many of the participants were able to see how children were raised, as well as how to care for a baby from their common experiences with younger siblings or relatives who always remained in the community fold. This knowledge transfer happened through life experiences with babies and children throughout their lifetimes. However, many of the women expressed a lack of knowledge in the areas of reproduction, stages of pregnancy, labor and delivery, and how to care for newborns. In the mental/intellectual quadrant, it was important for the mothers to gain knowledge of the areas that are not publicly^{ix} discussed in First Nations cultures.

Most of the middle age and elder participants had very little prior knowledge of pregnancy and birthing prior to their own experiences. Since Mi’kmaq women are notoriously modest about their reproductive side of health, it was uncommon for women to speak openly about pregnancy in a public form in the past. Pregnancy practices were only spoken of in the female realm, and modeling behavior was more common than speaking directly to the issue. Therefore, most elderly participants had very little knowledge about the reproductive system and how babies evolved in a life cycle. The younger participants were able to use intellectual supports such as books and more recently the internet, but the elder participants often mentioned that they had to be “clued” in to what would be expected in the coming months as these intellectual supports were not available.

Rose: “Well the first time I got pregnant, of course, um I was elated, I wanted a baby, I wanted a baby right bad, that is when my aunties, clue me on the things that I have to do, or do in the next 9 months, that I’m expected to do”.

F-6: “I didn’t know what I was going through, cause at that time you had to look up in the dictionary what sex was <laughter> you don’t have sex talks in schools in my days, PDR, and all that, no way you don’t talk about sex then, holy shit you’re in trouble, that was different than from today”

^{ix} Women’s reproductive health was often taught only within the women’s realm, men received their own teachings on the topic, but women only spoke about birthing/pregnancy within other women’s company.

Another elder, Ivy noted it was her husband who informed her about family planning methods, and was eventually the one to discover she was pregnant. This disassociation from one's own sexual health highlights the gap between sexual health knowledge and the teachings of residential school. The elders in the group knew about sexual activities but often were not sure about the process and stages of pregnancy. They were often told that God was the reasoning behind pregnancy and that having a baby is like having a bowel moment. There was very little mention of the upcoming pain and what to expect during labor. Most elderly participants were unaware of processes of reproduction and thus information on birth control came too late, as they were often pregnant within a few months of engaging in sexual activity.

This situation was different for participants who were in their 20's-40's who had information resources on their reproductive health, yet still chose for their own reasons to practice unsafe sex that led them to their pregnancy. One middle-aged focus group participant noted, *"Sex education came too damn late, I was already pregnant. When I got to grade 9, that's when they started to teach that."*

Most of the younger participants were aware of birth control and the reproductive processes in comparison to the elderly participants. Yet, most women chose to become pregnant at a younger age, showing that no amount of resources on sexual health deterred their plans to create their own families or to gain status as "women" in their communities. Since independence and "growing up" status can be seen as a benefit of pregnancy, I wonder if this may have been a motivating factor in becoming pregnant. Today, reproductive health information is quite accessible through Internet sites; however, there seems to be a pull towards motherhood that supersedes information about sexual health that is out there and available to the younger participants.

THEME 3: Birth experiences and teachings of Mi'kmaw Women

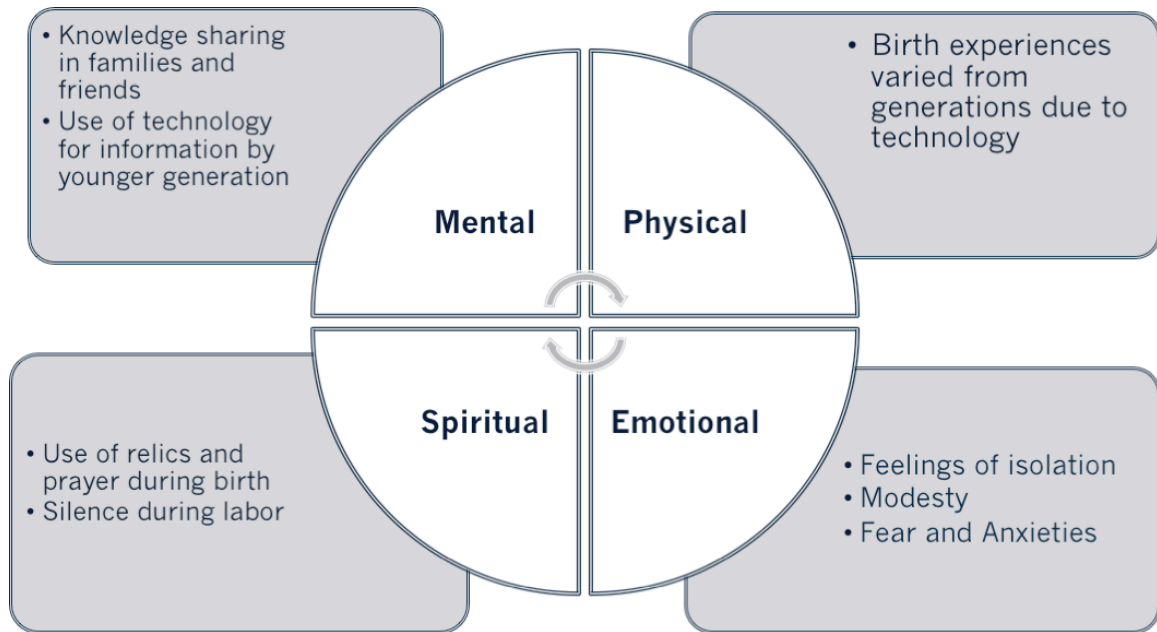


Figure 7: Theme Three Medicine Wheel Roadmap: Birth experiences and teachings of Mi'kmaw Women

Physical Quadrant:

Many of the participants spoke about their birthing experiences with each of their children, which were personal and unique to each participant. Birthing experiences varied across the generations, as the elders talked about the lack of knowledge and fear that birth brought. One elder Ivy noted *“I didn’t know anything about having a baby, I asked all my friends, its like being constipated they told me, I was scared I was going to wake up one day and the baby would be in the bed”*. The younger generation participants were far more knowledgeable about procedures due to more education with maternal health professionals, and were part of a more open environment amongst women to talk about their experiences within the delivery room. The younger generation also had more experiences with C-sections than the older generation. The younger generation talked at length about the medicinal interventions during birth, such as use of ultrasounds, inventions to speed labor, pain management, water-breaking procedures, and

technological monitoring of their labor stages. The elders did not speak at great lengths about their births, which is consistent with how birth is perceived as a private event, where even their husbands or support partners were not allowed to be in the delivery rooms. These cultural changes show the society and culture shapes each woman's birthing experience.

Emotional Quadrant:

Many of the women who have given birth noted that birth is both a private and a family event. Many of the elder participants noted how they gave birth on their own, with no supports at hospital settings. They felt isolated, but at the same time they did not want a big crowd to attend the birth.

Rose: "It's a private thing between you and your husband, you created it, you don't need another, 3rd 4th person, in there, watching your ass open up."

April: "Like if even if I have another one, I don't want my own mother there, that's how much I don't want anyone there. Like there is nothing they can do for you. I'll call them and tell them I had the baby."

One younger participant had too many people in the delivery room and felt that her privacy was being invaded as she lay there exposed and other men from her husband's family were coming in the birthing room. She decided after that experience that she would not call anyone but her husband when she was in labor and have a private birth. Modesty is virtue for all Mi'kmaq women, and the birth of a child, is a time when a woman is dealing with all four quadrants intensely and simultaneously, physical pain, emotional distress, mental focus, and spiritual faith.

The emotional quadrant during birthing is a particularly important aspect of birth. After giving birth, women receive a surge of hormones that allow the mother and child bond to be realized¹⁰⁰. Many women assert that the birth of their child was an event when they "felt like real mothers."

Rose: "They are so precious. And when you have them, it they become a part you, you're a part of the baby while you're expecting and you're continually be a part of the baby, and the baby is a part of you."

For most new mothers, pregnancy is a time of anxiety, fear, and unfamiliar emotions that can be attributed to shifting hormones, bonding as a family with partners and the new

emerging body attached to a human being, and the transitioning of their role from young girl into mothers. Many of the participants spoke of their fear and anxieties that they dealt with during their pregnancies and the uncertainties they had about motherhood.

Spiritual Quadrant:

The connection to ‘Spirit’ is an important concept in Mi’kmaw culture. The belief that the child has awareness of its environment is rooted in many of their values and beliefs about pregnancy. An example of this is the Mi’kmaw value and practice of being silent through one’s labor. All the participants tried to live up to the Mi’kmaw virtue of being silent, calm, and following natural labor during the birthing of their baby. The participants were reminded often about this practice during pregnancy, and I would even suggest that it is a part of the grooming process for Mi’kmaw women to hear of this tradition. The reasoning behind the silence in labor is that the child emerging from the mother would be scared to come out if s/he felt that the birthing process was violent or held bad energy. The belief is that any negative behavior would scare the baby and may cause the baby to choose not to come out and instead return to the spirit world. This belief is upheld presently and all the women talked about their efforts and fears about trying to live up to this traditional practice.

May: “I felt like I was going to lose it, like start crying and freaking out, and this Mi’kmaw women have to be quiet when they are having labor, I couldn’t live up to it, I couldn’t live up to it... That Mi’kmaw women aren’t loud, it helps you know, it’s a bad atmosphere, and your just wasting energy, if you’re loud that is.”

Rose: “One of the things they told me was don’t make awful noise when you’re having your baby, don’t scream and don’t curse and don’t yell, because they said the baby is coming to the world and they don’t want to come in the world that is violent. And being mad and angry and cursing at your husband, and screaming is a violent behavior, and though when you go into labor, I kept remembering that. I can’t scream I can’t scream cause I’ll scare the baby, and something will happen to it, even though you’re in awful pain but you manage to manage to, ah to subdue yourself.”

June: “I was dead set against taking anything cause my mom didn’t take anything, so I was like I’m not, if my mom didn’t need anything, with her 5 kids, what makes me so special, so I said I’m not going to take anything... I didn’t say a word, I

didn't scream or nothing, every contraction I was laying there and trying to relax, that's the best way to do the nurse was saying, it was going off the chart and I would {deep breath} or just squeeze a facecloth in my mouth or just laying there, and I didn't want to take anything."

The participants who lived up to the Mi'kmaw expectation to be silent during labor delivered a great deal of pride in their delivery experience. It's a common saying that if a mother follows the protocol of silent birthing without drugs that she is considered "tougher" or "stronger" in comparison to other women who did not. There is often a dichotomy drawn between "white women" and "Mi'kmaw women", where white women are thought to be the example of what not to do during labor-- that is scream or yell at their husbands as First Nations women do not. In the history of Mi'kmaw women who delivered in hospital settings, there have been more cases of women giving birth in hallways without the help of any staff. Rose noted that she witnessed a Mi'kmaw woman who silence in labor resulted in an unattended birth.

Rose: "We were in the same labor room, and I was having [my baby], and she [other Mi'kmaq woman in labor] wasn't saying a groan, I didn't say very much, she got up from her bed and went to the bathroom, and then she called me [Rose] I think the baby came" and I called the nurse, and they came running over... and sure enough, she had a boy... What they did later on, is keep close eye on First Nations women, cause they don't say anything, they don't tell, or scream at the nurses, that the baby is coming, they don't say anything, lot of babies are born on the bed."

Their silence causes them not to get the attention of hospital staff when it is time for their delivery. In addition, it causes a perpetual stereotype of First Nations women of not feeling pain in labor or not feeling pain in the same way as European women. Since in the Catholic tradition labor was a curse given to Eve for eating forbidden fruit, the early missionaries such as Father Chrestien Le Clercq⁹⁶, who came in the early 1700-'s noted that First Nation women did not feel labor or pain during delivery. The belief has since been challenged and currently in hospital settings, staff are being trained to be more sensitive to this cultural practice and to pay special attention to First Nations women during labor.

The participants were all fairly religious in the Catholic faith and have used prayer during their pregnancy at one point or another. Some used it as a coping

mechanism during labor, or a bargaining tool with God to make everything go smoothly. Others used it while dealing with a difficult pregnancy as a way of managing their feelings. One woman, Daisy was very ill during her pregnancy and had to remain in the hospital during the last trimester of her pregnancy. Daisy used her faith and prayers to ease her boredom and for coping with her fears for her child. Before labor, she was so sick that a nun was called in to give her last Catholic rites in case she died during labor.

Daisy: "I have a nun in my room, you know, praying over me, I'm not you know, I'm a spiritual person, but anything like structured, so, anyways, she comes in and she's praying over me, and praying for the baby."

Daisy's family also used prayer also when her child was in the neonatal ward. Prayer was evident during labor as a pain management tool, as noted by one elder, Lilly, who emphasized the importance of remaining calm during labor:

Lilly: "She said whatever you do she said don't make noise, all you do is pray, pray, pray, don't make noise, only white people make noise, holler, and swear at the nurses, that's all the white people do, whatever you do, don't do that."

The use of prayer was discussed in all the participants laboring experiences. This can be explained as a connection to body-spirit that has been a traditional value and a value that is reaffirmed by the Catholic Church.

Mi'kmaw people celebrated on June 24, 2010 their 400th year anniversary of the Mi'kmaw peoples' baptism of Grand Chief Membertou along with 150 other Mi'kmaw people⁷². Since that time, Mi'kmaw people have grown in their understanding of Catholicism, its rituals and ideologies, although they have continued to cling to their own spiritual beliefs that have mixed with Catholicism⁷². While many aspects of Catholicism are still practiced faithfully among most Mi'kmaq, there are those in the younger populations that have less knowledge about the doctrinal aspects of Catholicism and practice their brand of Mi'kmaw spirituality, as evidenced by the participants' views on their faith and on their practices associated with it. Despite these views, they still hold strongly to the belief in the spiritual sacred nature of new life, of the sacred vessels that hold that life and of the need to protect that spirit as it enters this world through their mothers' delivery.

Mental/Intellectual Quadrant:

Many of the participants' information about births and pregnancy came through observing other women who were pregnant. Many of them were unsure about how to take the knowledge they received by the doctors and process it through their Mi'kmaq knowledge filter, as some times the Mi'kmaq elders in the community would contradict what doctors told the pregnant women. It was a struggle for the women to be in two separate lines of knowledge as the Elder Rose noted:

Rose: "I was on the threshold of still believing in my ancestry, that I still have a strong relationship with my ancestors and everyday it was reinforced, but also I did a lot of reading, for my courses, for my high school schooling, I knew these things conflicted with what they telling me, so therefore I was sitting on the fence, oh my god, who am I going to listen to, the book they tell us this, and then these people are telling me another thing, and you have a hard time uh getting off that invisible line and standing in a position that you are comfortable, that I'm not hurting anyone, them telling me this and I'm not also hurting what I read. I can combine the two and maybe that would work."

This participant spoke of the struggle of walking the two worlds during pregnancy and birth, the Mi'kmaq traditional beliefs and practices and the western medical science beliefs and practices. Since knowledge about pregnancy and birth came in many forms, it was hard for elder participants to put their faith in one or the other. However, the younger participants had a wealth of knowledge available to them, through media, health centers/professionals, and Internet, pamphlets and family/elder advice. Other younger participants used online sources and bought books about pregnancy, so that it could help them understand what was happening to their bodies. It seemed that the younger participants were able to negotiate the information they received, and could be more critical about the information they received. The elders seemed to rely solely on what elders in their era told them, and the advice from local midwives. Regardless of the amount of education on the topic, birthing experiences involved each participant struggling through the pain, the discomfort and the anxiety of giving birth, and the resultant joy at the end of the experience, when their births were successful.

THEME 4: Maternal Health teachings during the Fourth Trimester and Motherhood

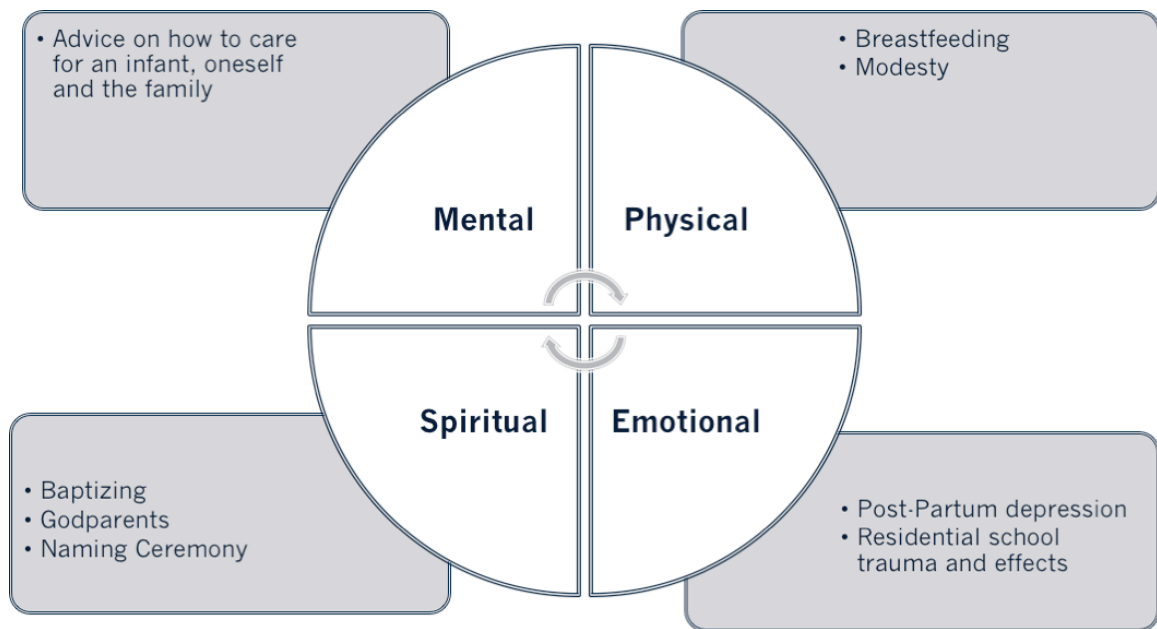


Figure 8: Theme Four Medicine Wheel Roadmap: Maternal Health teachings during the Fourth Trimester and Motherhood

Background on Mi'kmaq mothering roles:

Traditionally once a woman chooses their life partner to live with, it is the partner's responsibility to care and provide for the families. However, this has been transformed under policies of colonization where men have few occupational or career roles since little economic development exists on reserves. Most of the populations on reserves live in poverty, thus having to become co-dependent on social welfare. These conditions create diminished roles for men compounded by a residential school history that has further affected men's self-concept and self-esteem. Coping mechanisms include alcohol and drug use, exaggerated dominance over women, or multiple partner scenarios; all of which create anxiety, tension and quarrels among families. Men are also more likely to leave their families and communities to find work elsewhere, thus leading to fragmented relationships with their children or with their partners. With fragmented cultural roles, couples are struggling to straddle two worldviews and maintain a

traditional family. Single mothers dominate the demographic profiles within First Nations communities, although many of my participants were in a relationship with a male partner, and the male partner was able to provide childcare during the time that the interview was being conducted. Therefore, women with male partners had a greater ease in participating in the study than a single mother might have.

All the participants had started to have children as young adults between the ages of 15 and 23 years of age, with the average age of the participants' first pregnancy was approximately around 19 years old. Many of the elders noted that in their time, having children when one was young was to be expected, and that most women were married by the age of 18. All the elders were married or in common-law relationships during their pregnancies. The elder participants also noted, that the younger generations should not be having children as early as they do, as there are more life opportunities available to the youth today. Elders think that education is important and one should wait until after high school before having a first child. The elders also noted how many of the mothers of this generation are often raising their children on their own with little help from the fathers, and are forced to live with extended family in overcrowded situations. Since most elders were married at a young age, they had husbands and extended close-knit families to support them. The elders pointed out that current society is much more reliant on social welfare to provide for their children, as there are very little support systems in place for single mothers in the workplace on reserve.

Physical Quadrant

In the physical quadrant of the third trimester, breastfeeding was the major topic. In the literature of First Nations people, "Our poor Indian women have so much affection for their children that they do not rate the quality of nurse any lower than the mother. They even suckle the children up to the age of four or five years" (Ganong⁹⁶, p.91). The Father Christien Le Clercq, noted how Mi'kmaq women did not use wet-nurses as is custom in his home land, and were to 'suffer' breastfeeding for long periods of time in the early 1900's⁹⁶. However, breastfeeding amongst the participants varied greatly, and it was interesting across the generations how attitudes towards breastfeeding changed. During the 20th century in Canada there were larger social shifts against the practice of

breastfeeding, so that mothers would be more able to join the workforce, such as during the Second World War. Companies also pushed women towards becoming “modern” through bottle-feeding advising that this was a new and better way. In the 1950’s to 1980’s, there was a campaign against breastfeeding, fueled by commercial formula companies, which been shifted due to social attitudes towards breastfeeding¹⁰¹. By 1990’s attitudes towards breastfeeding had begun to shift reflected in the World Health Organization (WHO) and UNICEF outlines for hospital policies to protect, promote, and support breastfeeding¹⁰². Many of the younger generation have chosen to attempt to breastfeed, some as a consequence of family/medical pressures, some believed from their reading and talking to elders that it was “the best” for the child, and for others, it was a cost-saving and was more convenient than bottles.

All the elder participants in the study did not breastfeed; and I questioned whether they were given much choice when it came to this decision. One elder participant noted that the hospitals gave her a needle shot to dry up her milk at the hospital, without giving any advice or allowing her to attempt to breastfeed first. The elder Rose, spoke about being told she was unable to produce enough milk without the nurses ever allowing her to try the breastfeeding option. Another elder from the focus group spoke about how breastfeeding was taboo for a young teen mom, and how pressures from society kept her from breastfeeding. The elder Lilly, spoke about how her high blood pressure medicine prevented her from being able to breastfeed, and how her babies were able to leave hospitals before she was released; therefore, she did not have time with her babies to breastfeed.

The younger participants spoke about breastfeeding in great detail, often noting how they chose to or chose not to breastfeed their children. Breastfeeding showed how Mi’kmaq values like modesty were influencing their behavior. One younger participant, May noted, “*When I breastfeed I didn’t leave my room*” and similarly another younger participant June noted, “*I was private though, I feed in the bedroom...I was just adjusting to it, finally after two months, It was so convenient I found, I could feed him anywhere, we could be shopping at Wal-Mart and I just go into a dressing room*”. These younger participants were able to breastfeed and still feel like they maintained their privacy and modesty through their actions. Other younger participants like April, felt a great deal of

pressure to breastfeed from the hospital staff. They noted that the women who breastfeed were given better treatment than the women who chose not to breastfeed at the local hospital in Cape Breton. At one time, bottle or formula feeding had been the norm in Canada, as it was pushed by western medical practices, and endorsed by formula manufacturers and Canadian hospital policies¹⁰¹. The more recent shift in pressure to breastfeed may have contributed to more of the younger participants choosing to attempt to breastfeed and having more success than the elder participants. It also shows how society's attitudes towards a maternal health practice can have a positive or negative impact on its success rates. Modesty and body image issues should be considered in breastfeeding programming and policies aimed at Mi'kmaq women as it holds a great deal of power in decision making of whether to bottle or breast feed.

Emotional quadrant

Post-partum depression in the third and fourth trimester amongst the participants was an unexpected finding of the research. The research questions only sought to discuss what the participants were provided as health promotion on the topic of post-partum health. But the findings were that most of the younger participants identified themselves having a range from having normal "baby blues" to postpartum diagnosis. An interesting finding is that the elders addressed the topic about post partum depression in a different manner than the younger participants. They would note that during their generation's upbringing, they had never heard of it, so they didn't think about depression in the same way. This is consistent with the relative recentness of the biomedical diagnostic category of post partum depression. One middle-aged participant thought it was not a part of the Mi'kmaq cultural make-up to have "baby blues".

Violet: "I think, nobody has them [baby blues], you know, its ah its a white thing...but I never ever remember anyone who went through that, nobody ever said anything like that".

Another elder Rose noted similarly:

*Rose: "Well we weren't aware of it, until they started reading the magazines *MI'KMAW (oh that must be what's happening to me, / going on with me) you know they tried to compare themselves to the reading, and yup *MI'KMAW (yup that's what happened to me) while it was happening to you, you were unaware of it, cause nobody knew of it [post-partum]."*

The elders suggested that it was a cultural trait not common for the Mi'kmaq and that it was brought into the community through other means, such as outside influences of media and Eurocentric culture. The elders were essentially saying that post partum depression was a part of another society that we emulated, instead of being a natural part of post-natal health, where hormones crash and women feel overly emotional. The way the elders spoke about post partum health was surprising considering that most of the participants experienced what would today be named as various symptoms of post partum depression.

The younger participants all spoke about their struggles in motherhood, and the onset of post partum depression. Many of the women attributed their depressions to their feelings of being “isolated”, “overwhelmed”, that “no one helped [them] enough”, and being “so exhausted” or “tired”. One participant, April noted: “I was very emotional, I was crying like crazy, like hysterically crying like a baby. But I couldn't help it, it was just like that's the way it was”. One of the younger participants talked about how they felt post partum blues was a social taboo as many of the community members would “talk about” women with baby blues:

May: “I think I got it [depressed] even before I had the baby, I looked at it a little bit, and I was darned to you know not have baby blues either, cause you wouldn't believe how much people talk about someone with baby blues. You know, I didn't want to be talked about, so you know, so I just threw myself into my baby. I don't even think I had time for the blues.”

The younger participants spoke about having a hard time during nights especially, as there is no one else to be awake to help them with the baby, like April's experience: “I would just sit there and crying at night time, holding my baby crying”. Many of their depressive episodes were in private and they felt that they were not living up to social standards of the “super mom”. One participant noted that her depression was just another cause of lack of time for “taking care of herself”. These women struggled with depression, and spoke about eventually “snapping out of it” because they had to focus on their children.

Another interesting finding in the post partum discussion was the observation three of the women made about their partner's reactions to their post partum depression. One participant noted how her partner became distant and turned to gambling as a means of disassociation from the situation. That participant spoke how his reaction made her

depression harder to deal with, as she felt like she had no support from family members. The other two participants noted how their partners tried to help them through their difficult situations.

Violet: "My boyfriend thought I maybe had post partum depression, felt like he didn't want to upset me, cause his sister had it, and she was kind of nutty when she had it, and he thought I would do something nutty."

June: "I would just cry cause I felt sorry for them [children], nothing even wrong with them, for two weeks, we were at the doctor's office, and they have a poster, and it said "are you feeling down?" near where the poster was a hotline, and [my partner was] like "take it", and I was like "No" ... I'm lucky mine [post partum] only lasted a week and half, 2 weeks."

These women spoke about their experiences with post partum feelings and how each of their partners took an active role in trying to help them through their depression. These women also noted that they felt the social taboo of having post partum depression, so that at the time they didn't see their depressive feelings as something separate from learning to be a mother. They all experienced suffering from lack of sleep and being overwhelmed by their situations. Their partner's support was only appreciated later after some reflection.

The issue of postpartum depression was unexpected but also telling of cultural values. The elders noted that women should not have negative postpartum feelings as they should love their babies more than themselves, but the younger participants found that depression was an individual experience that was common but not spoken about in the community. They each had to cope with the depressive feelings that were something that they alone experienced due to the changes in their lifestyles, lack of sleep, lack of support and feeling emotional due to fluctuating hormones. One study¹⁰³ considered the appropriateness of screening tools for Native Americans in post partum, arguing for a consideration of the impact of the assimilation and colonization history. I would have to agree that social context indeed affected the mother's likelihood of having post partum feelings. The elder, Ivy, noted how residential school affected her depression during her pregnancies, as she found it hard to understand how anyone could leave their children in a school and never see them. Ivy spoke about feeling resentful towards her own mother, and wanting to protect her children from the harms that were done to her at residential

schools. These are instances of how the collective trauma of colonization¹⁰⁴ of the family, and the generational effects of residential schools affect all aspects of Mi'kmaw culture. Often women are forced to deal with these residual effects and their own emotions after birth to try to be the perfect mother and provider.

Spiritual Quadrant:

When looking at spirituality during and after pregnancy, it is hard to identify which spiritual traditions are being used as they are often intertwined with other religious and cultural practices. Almost all my participants had participated in Catholic traditions of baptizing their babies. These ceremonies are important features of relation building in which the mothers and fathers pick Godparents. This western religious practice is consistent with a First Nation belief that emphasizes the importance of relationships and the community spirit of extended families raising children. Mi'kmaw people believe a community raises the child and this belief is shown through this Catholic ritual that allows the parents to pick a male and female guardian to take on the extra responsibility of raising the child as their own. The baptism is also a symbol of celebration and renewal in the community. Children are presented to the community at this ceremony and often there is a feast that follows at the child's home to honor their joining the family.

This contemporary form of presentation to the community is similar to a naming ceremony of the past. The church dictates the schedule of this ceremony, but it is often the community members that request the ceremony to be done. The Mi'kmaw tradition says that a child is not to leave the family home until this ceremony is completed, so that the child's spirit is recognized and greeted properly into the human world. If this is not followed, it is said that the child's spirit may wander away from the child and get lost and result in sudden infant death syndrome. There are many Mi'kmaw beliefs that surround the spirit of the child, and participants were cautious not to disregard them.

Mental/Intellectual Quadrant:

Most of the participants were given advice on their health after pregnancy. The elders mention how their aunts, mothers, and female family members surrounded them after pregnancy. They noted that they were made to stay in bed for up to two weeks and to accept domestic help from the women in their communities. Women were expected to only care for the baby and herself in the weeks following birth; all other chores were allocated to other family members. The elder participants noted how times have changed, as current new mothers of present don't appear to want elders' help and don't follow traditions of the past.

Rose: "No, no, they don't do that now, and the old ladies would say, you know what, she's going to have a hard time, with her stomach when she's 40 or 45, because she had a baby yesterday, and she's walking around, and they don't want that, they say she'll pay for it, she pay for it. And they're right, they do pay for it. But you can't tell that to young girls, they know everything."

Some new mother participants noted that they did have mature women who would come and visit the baby after pregnancy and offer advice on birth control, breastfeeding, and behaviors that were expected of the new mother. The younger participants noted how they welcomed this advice and attention in the weeks after having their child. Many of the younger women noted how they struggled with their new roles as mothers, once the attention had slowed and were often distraught with feelings of inadequacy of not living up to standards that they perceived they were being judged on.

Conclusion:

There has been a wealth of knowledge shared by the fourteen participants that were involved in the research process. Each participant shared private and intimate stories about becoming women and becoming mothers. The participants' data provided a significant amount of information to consider how maternal health knowledge is transferred from one generation to the next. The knowledge gained from health professionals and their Mi'kmaw communities are being passed on through storytelling. These stories also helped identify how Mi'kmaw values, beliefs and cultural traits shape the maternal health experience of Mi'kmaw women. I grouped these stories according to

4 stages of life course surrounding womanhood, pregnancy, and childbirth and further explored each of these life stages through four quadrants of a human wholeness medicine wheel that captures the physical, emotional, spiritual, and mental aspects of each life stage experience. The goal was to explain how Mi'kmaw women interpret their cultural, societal, and personal values during pregnancy and childbirth.

In theme one, the process of a Mi'kmaw girl becoming a woman is full with teachings and lifelong lessons. The physical quadrant focuses on the teachings around the sacred nature of female menses and the womb within the Mi'kmaw worldview. The participants' stories, however, are characterized by a disconnection from the female body as a consequence of colonization and residential schools, showing how they, along with their culture, have been impacted by this history. In a contemporary context, teachings about becoming a woman are used to show young women how to behave in a culturally appropriate way that incorporates traditional values and Catholic influences. The emotional quadrant focuses on how the women relate to womanhood and the teachings regarding becoming a mother. The spiritual quadrant helps lay the foundation for cultural teachings for women to understand their roles in society. The mental quadrant shows how the values of motherhood are embedded in the language and reinforce the value of becoming a mother in the Mi'kmaw society.

In theme two, the focus is on how pregnancy is dealt with from conception to labor in a Mi'kmaw context. The physical quadrant offers the participants' diverse experiences associated with prenatal screenings and their views of how maternal health changed over time from the 1950's to present. The emotional quadrant examined how life-altering pregnancy was for the participants, and how it resulted in many of the participants choosing to hide their pregnancies until they were ready to take on the 'mothering' role. The spiritual quadrant addressed how Mi'kmaw women used religious relics, prayer, and traditional spiritual teachings during pregnancy to ensure their children's spiritual and physical safety. The woman also emphasized their struggles with walking within two worlds, their Mi'kmaw traditional teachings, knowledge, and value systems and western society's imposed medical knowledge systems. The mental quadrant discusses how sexual health and maternal values were taught to the participants, and how they gained knowledge on maternal health.

In theme three, the focus was on the birthing experiences and teachings that go along with the momentous occasion of bridging a child spirit from the spiritual world to the physical world. In the physical quadrant, the focus was to emphasize the difference among the generations in their laboring experiences and community values. It was significant that the main difference is that younger generations are far more knowledgeable about the biology of pregnancy and birthing, emphasizing the rise in medical interventions when current technology is available compared to the lack of knowledge of birthing among elder participants who also had minimal maternal interventions at their births. It is also significant that there were higher morbidity rates of infants among Mi'kmaw women in the earlier years such that they had many teachings for how to keep babies alive, drawing on their spiritual connections. The emotional quadrant relayed the message that birthing is a private event among Mi'kmaw women and is a bonding event for the participants. The spiritual quadrant emphasized how the participants' Mi'kmaw belief systems shaped their labor management and birthing behavior. Silence during labor is a consistent value across the generations, as is the role of spirituality and religion as important factors influence their birthing experiences. The mental quadrant examines how knowledge systems clashed during birth, as they negotiated contradictory medical and traditional advice about birth. Theme three has focused on how varied knowledge transferred amongst the participants on the topic of birthing and labor.

In theme four, the focus was to speak to the participants' 'fourth' trimester of pregnancy, a period of adjusting to their new mothering roles with an infant. Mothering roles have changed a great deal in Mi'kmaw context as social roles have changed over the generations. In the physical quadrant, the emphasis was the change in social attitudes towards breastfeeding amongst the participants. In the emotional quadrant, the focus was on the post-partum experiences of the participants and how perception in mainstream society changes the acceptance and acknowledgement of 'baby blues' in a Mi'kmaw community. In the spiritual quadrant, the focus was on the relationship between traditional values and the Catholic Church and has embedded the ceremony of presenting a child to the community in a religious form such as baptism. In the mental quadrant,

participants examine how knowledge transferred from Mi'kmaq 'old ladies' has helped women adjust to their new roles as mothers and caregivers.

The life themes created out of the chronological timeframe of pregnancy and motherhood has allowed for each participant to speak to her individual experiences and her collective folk knowledge of the Mi'kmaq people. Each theme focused on all the physical, emotional, spiritual, and mental quadrants of the medicine wheel. However, each life theme seems to have a dominant quadrant, which best explained how maternal health knowledge is transferred from one generation to another, as well as how each Mi'kmaq generation through the fifty year span of the participants experience has changed along with the mainstream society. Each theme had allowed the participants to note the changes in Mi'kmaq culture due to residential schools, exposure to technology, and the changes in medical health delivery.

CHAPTER 5

DISCUSSIONS OF FINDINGS

Following a brief reiteration of the study objectives and questions, this final chapter will discuss three areas to draw together the results of this study of Mi'kmaw maternal health knowledge, behaviors, and beliefs. The first area is a consideration of the history and context of the population from which the Mi'kmaw women participants in this study was drawn, and within which each of the participants' lives has evolved, creating situations and consequences that contributed to the maternal health decisions or choices they made. The second area is a revisitation of the Indigenous conceptual framework that framed the research and which helps the reader to interpret Mi'kmaw women's lived experiences and their transition from girl to woman, and then to a mother. Third, I touch on the major themes of the research according to the questions I asked, bringing forward those of applied relevance as well as areas to pursue in future research in this area. Strengths and limitation of this work are provided. To conclude, I weigh the implications of this research to health care systems, to First Nations education systems, and to the Mi'kmaw Nation suggesting a need to consider returning midwifery as a way of reclaiming and reconciling Indigenous knowledge systems, and as a way toward women being as self-determining as their ancestors were about their bodies, relationships, and birthing.

Objectives

This qualitative study focused on Mi'kmaw women's lived experiences, in particular drawing on the narrative stories of fourteen Mi'kmaw women who had experienced their pregnancy in the last fifty years, in First Nations communities and in urban communities, and how they infused Mi'kmaw cultural and spiritual knowledge into the care for themselves and their growing babies, and how these resulted in beliefs, attitudes, perceptions, and practices that continue to shape maternal health among Mi'kmaq in Cape Breton, Nova Scotia.

There were two main objectives of the study. The first was to gather knowledge about pregnancy, childbirth, and new motherhood experiences of the Mi'kmaw women in

Cape Breton, Nova Scotia, which is the homeland of five Mi'kmaw reserves and of a growing off-reserve population in nearby towns. It is hoped that the data created from these fourteen Mi'kmaw women experiences may inform the development of more culturally appropriate maternal health programming and services for those Mi'kmaw women living on-reserve/off-reserve.

The second objective was to identify a framework that would provide a foundation for the study and its analysis of data, would incorporate traditional and western knowledge, and would inform Indigenous experiences of maternal health with the current literature, thus filling an identified gap noted in the literature review about First Nations' women voices, experiences, and perceptions. These objectives aim to empower Mi'kmaw women's collective knowledge and provide opportunities to participants to identify areas leading to needed changes in maternal health program in their home communities.

Review of the Research Questions:

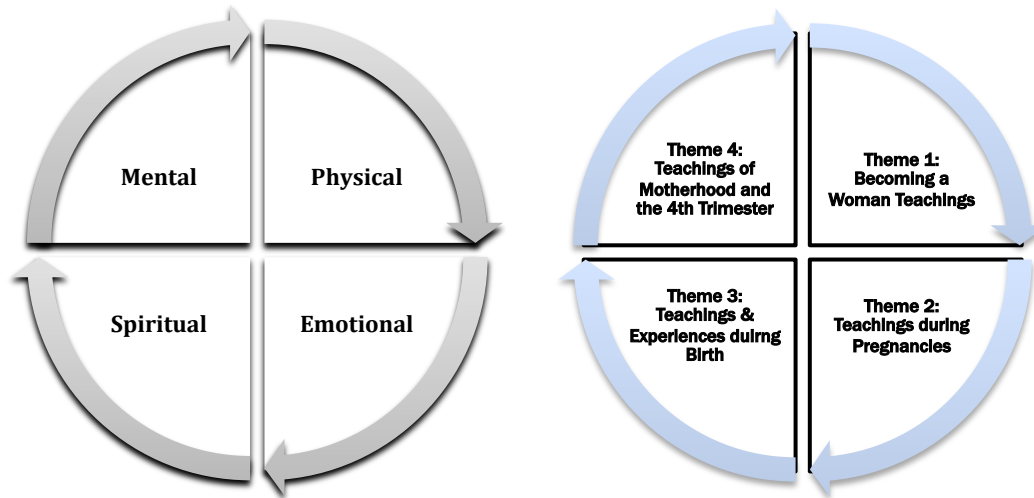
The Mi'kmaw participants were asked to discuss their maternal health stories in order to identify how Mi'kmaw women perceived experiences of pregnancy, childbirth, and early motherhood within the context of living on-reserve and receiving information, knowledge, support, and health care services within in a fifty-year span. This period has been significant as Mi'kmaw health care has gone through some significant changes, some due to the limitations imposed by the government of Canada in the *Indian Act* and its agent, the Department of Indian Affairs, as well as the changes that came as a result of health care services under First Nation's management. The study sought out Mi'kmaw traditional knowledge regarding maternal health care, in addition to the biomedical experience, to consider knowledge systems and how they are applied, as well as to highlight disparities in maternal health experienced by Mi'kmaw women. One goal of this research is to provide information that may be used to improve maternal health care among the Mi'kmaq women living in Cape Breton, Nova Scotia. There were four main research questions, which were used to frame the narratives of the Mi'kmaq participants:

1. What are the experiences of maternity and childbirth for Mi'kmaw women over the last fifty years (1960-2010)?

2. How is Mi'kmaw traditional knowledge about pregnancy and prenatal care learned among Mi'kmaq women and what significance does it have for health care among women in the First Nations communities of Cape Breton?
3. What are the complementarities and conflicts between Mi'kmaw knowledge and practice and western knowledge and practice and health experiences of maternity over the last fifty years? How do these knowledge systems interweaving together affect Mi'kmaw women's decision-making process during pregnancy and birth?
4. What are the implications for improving maternal health care that would reflect the values and beliefs about pregnancy and childbirth for Mi'kmaw women?

These questions guided the research discussions that were also placed within the organizational framework of a medicine wheel. Many other First Nations communities may have similar experiences or cultural values, but it is important that the reader not generalize the findings to all Mi'kmaq or to all First Nations cultures. The findings are meant to offer insight to health professionals and maternal health program developers who find themselves working in a First Nations maternal health a context with a special view into Mi'kmaw women's collective maternal experiences, knowledges, and beliefs. This knowledge emerges from research that was conducted by a Mi'kmaw female researcher, raised within a Mi'kmaw on-reserve context, and who has received her education both on reserve and off reserve. I am a single woman with no children, but have had a long-standing special interest in the area of maternal health and subsequently have had experience conducting research in the newly legalized field of Midwifery in Nova Scotia.

Framework:



By way of a methodological summary, I used a qualitative research method, drawing on naturalistic inquiry for the research to investigate personal narratives of Mi'kmaq women maternal health experiences. Qualitative research has the potential to bring the research and the participants together in natural settings, in this case in the homes and communities of the participants that allows participants to feel comfortable with natural conversation to speak freely about their experiences and allows the researcher flexibility in the interviewing process. Naturalistic inquiry also allows for increased flexibility in the data collecting contexts, ensuring the interviews matched well with the natural style of conversations instead of more rigid style of interviews involving questions and answers. Naturalistic inquiry in this qualitative design uses the principle that all phenomena are entrenched in a social/environmental context or natural setting⁸². Qualitative interviews can be unstructured and descriptive in nature, thus leading to unexpected significant contributions to emerge naturally. The research is not a means of testing a hypothesis but rather aims at gathering information to form a theory that allows the research to explain Mi'kmaq women attitudes, beliefs and knowledge's about maternal health in the context of a First Nations setting. The research used a phenomenological approach, which “emphasizes a focus on peoples’ subjective experiences and interpretations of the world” and asked questions about ‘how the world appears to others’ (Trochim⁸⁷, p.1). This approach allows the participants to speak about

their personal experiences learning of their pregnancies, the effects it had on them, the kind of care they had in the community, or in the health system, and the subsequent care after they had their babies. The research data was then categorized with the use of Atlas-ti software and categorized into themes using a medicine wheel framework.

The medicine wheel framework is an important aspect of the research to examine the findings as it is a structure and process for analyzing and illustrating the interrelationship of research themes based on an Indigenous lens. “The medicine wheel is a circular paradigm which can be used as a framework for understanding” (Smylie et al.³², p. 55). The medicine wheel looks at health in a holistic manner. As Dr. Marie Battiste notes, “the medicine wheel illustrates symbolically that all things are interconnected and related, spiritual, complex and powerful” (Battiste² p. xxii). The medicine wheel framework is important in creating a deeper understanding for maternal health professionals of the experiences of Mi’kmaq women and in addressing culturally appropriate approaches, services and programming in First Nations maternal health. By reporting on all four aspects of the medicine wheel, the research thus provides a fuller understanding of the participants’ experiences in multiple domains (physical, mental, emotional, psychological, and spiritual) and traditional knowledge transfer in First Nations community in the area of maternal health. By creating life themes using the medicine wheel, it had help create major categories of analysis in which the women experiences could be gathered and understood.

Context:

At the beginning of my research, I offered a brief context to the study, giving information about where the study was taking place and recognizing the various policies and practices under a colonial framework. What I realized as I got to the end of my research was how important the context and history of Aboriginal people were to their lives and collective experiences in maternal health. Issues such as colonization, Eurocentrism, patriarchy, sexism, poverty, hegemony, dominance, oppression, racism, and all the factors that contribute to these issues have deeply influenced the results and findings of the research. These women were not solitary actors in their choices in life and in pregnancy. They made their choices within the context of those factors that contributed

to their feelings of being dismissed and diminished by doctors and nurses, of living with prejudice, discrimination, racism, and poverty throughout their lives, and the effect these created on the systems they interacted with, the services they received, their perceptions about health care and about the value and utility of their Indigenous knowledge coming from the elders in the community.

The gaps in knowledge and availability of services among the young and older group of women were also significant, leading me to understand how cultural teachings like language are under attack by the modern colonization of our youth in formal structures such as schools and in the informal contexts of story telling, cultural practices, and protocols. The younger participants had greater access to maternal health knowledge in the western medical model but lacked understanding about their own cultural knowledge and traditional teachings that had been used among their ancestors for their own benefit and survival. This sadly ensures that future generations of Mi'kmaw women will have less access to these teachings, which makes the findings of this study more important to document for the future.

The context is an important factor to consider while doing narrative inquiry as it allows the participants to speak naturally about their experiences, but highlights the context that plays out in their maternal health experiences. Participants never explicitly named in their narratives racism, colonization or residential schools as a direct factor in their maternal health experience about their pregnancies, but when I looked deeper into their stories, I could pick out the many instances of how they were all very deeply affected by their socio-cultural political context. Because I was an insider to these issues and had studied these issues in relation to my community, I could apply my new understandings to this context in which these stories took place, and to examine further their experiences. The administration of the *Indian Act* in those communities directly imposed prejudices and discrimination through their policies in education and health reinforced by a rigid Catholic patriarchal educational system, and within that context, they have had to negotiate their lives, from childhood, to becoming a woman, to having children, and teaching these experiences to their own children. Women have learned about their bodies and sexuality in the absence of traditional knowledge that valued who

they were and could become. Instead, they learned about menstruation, sex, and pregnancy in shadows of their cultural ancestry.

My analysis of the data is augmented by the use of medicine wheel that offers a holistic framework implicit to Indigenous learning, and ways of knowing. Putting the participants' experience in the medicine wheel context favors Indigenous methodology and paradigms in health research. As an Indigenous scholar, I am trying to identify Indigenous Knowledge (IK) and Eurocentric Knowledge's (EK) in maternal health and find ways to negotiate ways to renew IK, to resist EK that imposes superiority on Mi'kmaw communities, to present a narrative of silenced voices of Mi'kmaw women in the area of maternal health, and finally to reconcile IK with western systems of health care. It was an on-going struggle to identify which knowledge sources were being used during the participants' decision-making in regards to maternal health, as the participants were not able to differentiate Indigenous knowledge from western medical knowledge. In my probing of the participants, I often found that they had little knowledge of what was different from Indigenous teachings and those they assumed were normal to western knowledge or non-Indigenous women. I often rephrased questions to help identify practices of the participants, to seek out traditional knowledge, because for the most part, the women were unaware of their cultural context in which they were embedded, and as a result, they could not step back and see how their maternal experiences were different from other women, with exception of birthing in silence which all seemed to accept as a Mi'kmaw practice. Traditional knowledge has been so diminished by education, health systems, and political systems and within our own hegemony that the result has been a resistance toward sharing of traditional knowledge among older generations. The traditional knowledge of maternal health has been pushed underground along with traditional midwifery. All but one of the participants was unable to clearly identify what was traditional knowledge and what was just common folk knowledge in their maternal health. Folk-knowledge is different from traditional knowledge as it is specific knowledge that would be considered 'common' knowledge to a specific cultural group. Traditional knowledge is different from folk knowledge as it is generational teachings of maternal health, which have been used through the decades and gain strength through the years of trial and error. Folk knowledge of the Mi'kmaw women living in Eskasoni are

easy for the participants to identify as common knowledge, but not all Mi'kmaw women are privileged with the passing on of traditional knowledge due to colonization. Thus participants themselves were unable to put themselves in an outsider's position to explain the differences in maternal health knowledge and how they learnt about Mi'kmaq cultural beliefs around maternal health.

However, as a trained researcher and having been educated away from the community in a western educational system, I was able to unearth traditional knowledge in many forms from the other participants by replacing direct questions about traditional knowledge with a more general question about what they 'learned' from others about maternal health. In another research study conducted by myself, "A Feasibility Study of Midwifery in First Nations Communities in Cape Breton"¹⁰⁵ from the Tui'kn Midwifery Project, which was done concurrently with this study, I found a growing resurgence in the valuing of traditional knowledge within Mi'kmaw communities as they become more educated about their 'subjugated colonial experiences'⁵⁹.

It is also significant that the Mi'kmaw people in 2010 have just celebrated the 400-year anniversary of Chief Membertou's baptism, marking the Mi'kmaw peoples' continuing relationship with the Catholic Church⁷². During this time, the Mi'kmaw culture has been under cultural attack and the colonial discourses describing them as inferior, uncivilized and immoral persist. The renaissance that Mi'kmaw people are experiencing comes from their seeking to retain their Indigenous cultural lives, to live equitably in modern society, and to have the power to be self-determining in their future¹⁰⁶. This emergence of this scholarship and activism, together with the growth of Mi'kmaw education in First Nations schools and at the post-secondary level at Unam'kik College at Cape Breton University gives greater hope that Mi'kmaw people and their knowledge and practices will continue to survive and flourish.

When I looked at the literature created about Mi'kmaw peoples written by missionaries in their journals in the 1600's, I could identify how missionaries began to impose their notions of superiority on Mi'kmaw families. Father Christien Le Clercq was one such missionary who wrote a narrative on how Mi'kmaq women were horrified that European women would use wet-nurses for their children⁹⁶. He had also identified similar themes as my findings of the Mi'kmaw value system such as the high value of women's

modesty, their collective love of children, and how sexuality was natural part of their daily lives and it would appear that these values are very much alive in the Mi'kmaw communities of today⁹⁶. While these values are still evident in present day Mi'kmaq lived experiences, they have been tainted by the context of their history with the Catholic Church, the federal and provincial governments, and the health systems that have come from them. This leads me to believe that there is great resilience among Mi'kmaw people despite colonization in maternal health with fundamental core cultural values remaining unchanged. Since maternal health is hidden within the women's knowledge system and realm, it may have gone unnoticed until recent technology and western medicinal advances have taken precedence in maternal health. The loss of traditional forms of birthing such as midwifery in the community can be attributed to the attack on female traditional knowledge by patriarchal Eurocentric dominated western medical practices¹⁰,
107 .

As I conducted the research, my understanding of maternal health and traditional knowledge grew. I learned that the context in which people live is an important determinant of what resources are available, or considered to be available, to them. A story told to me outside of the research context, made a lasting impression. I was told that Mi'kmaq women were not welcomed in the early 1900's at nursing stations/hospitals, and that doctors paid by the Department of Indian Affairs who travelled to the reserves (sometimes monthly, but often without consistency) were the only source of health care provided to the communities. Ironically, I feel this contributed to the maintenance of Mi'kmaw women's maternal health through the services of traditionally trained midwives within the community. It was typical for women to gather together to help with a birth, as they did for death and other key events in the community, and some remained with new mothers for up to 6 weeks to help them along. I also learned that once women were allowed in nearby hospitals to have their babies, they felt privileged to be a part of the western medical model of health, and as a result, midwifery practices declined. Modern advances in health science and its introduction and use of various technological advances in monitoring women or assisting in birth continue today to have an impact, sometimes positive, and sometimes not, as when it devalues the knowledge passed down through elders. I began to question which knowledge system is prized at present and wondered if

‘modern’ women are losing sight of the value and teachings of maternal knowledge of our ancestors. Thus it is important to note the context in which Mi’kmaw women of the present are working through to shape their worldview. In the next section, I turn to answering my research questions those themselves evolved from this context.

Discussion of Research Questions

Once the research was completed, I created a list of Mi’kmaw traditional knowledge data that was compiled during the interviews and categorized them into themes, such as food, clothing, pregnancy behavior, and post pregnancy behavior (Appendix H: Mi’kmaq Traditional & Folk Knowledge). The process of organizing the traditional and folk knowledge of the participants was quite time consuming, as was developing frequency counts and considering why certain beliefs were mentioned more often than others. Some of the practices of the elders are now considered common knowledge in the community. These cultural specific knowledge’s were not seen as specialized knowledge from the general non-Mi’kmaw public. The confusion for me was to realize that I had to remove myself from the insider position to understand that common knowledge is subjective to the population, and that I had to remove my potential for bias to see what is traditional knowledge, folk knowledge, and common knowledge resulting from medicinal sources. For example, some of the women shared common knowledge practices for how to stop milk production among women wanting to stop nursing with cabbage leaves, which is now common knowledge in medical practice. Medical professionals often offer this practice as a means of reducing milk production for new mothers. While Canadian society may not understand or believe in the usefulness of certain beliefs regarding food, behaviors, or other spiritual connections that were shared with me, it seems to me there is also no evidence to make Mi’kmaw women change their thinking or ways of knowing, for there appears to be value in every tradition, myth, folklore, belief and practice of Mi’kmaw women during pregnancy. The research did not intend to judge the truth or validity of the participants’ cultural beliefs and practices, but rather I wanted to gather them so to find out which may be creating barriers for Mi’kmaw women in optimizing their maternal health.

Mi'kmaw maternity and childbirth experiences over last fifty years

The first step in finding out the answer to this question about maternal experiences of Mi'kmaq women was to ask elders about their experiences and to capture what the historical variances with maternal care, delivery and procedures. I wanted to find out about their lived history, comparing their maternal health foundation in the past with the more recent maternal experiences, determining what has changed and progressed in the community's health delivery. Initially, I wanted to explore the aspect of midwifery within the communities; however, I was to discover that all of the women I spoke to had their babies within a hospital setting. However, a few of the elder participants did remember the local midwife and her role within the community and could offer some perspectives on how the community perceived her as a respected medicine woman. This past history was rich, but limited, as many of the participants were unaware of maternal health experiences of their mothers or grandmothers, which would have made for a more dynamic understanding of maternal health. However, given knowledge about midwives and the racist policies which turned Mi'kmaq women away from hospitals in the early 1900's, one can assume that maternal health has had a great impact on traditional knowledge.

Most Mi'kmaw elders did not speak about their mother's experience as at that period of time before 1950's, most women were very conservative about their own personal experiences with child bearing and knowledge was provided only on a need to know basis. One elder participant, Lilly, noted how her own mother kept her pregnancy a secret from her children in the 1940's, only asking them to pray for a baby with her every night, until one night she brought an infant home and presented them with a sibling. Lilly's experience resulted in her naïve perceptions of how babies are made, causing her to believe that prayers had resulted in 'God' bestowing women babies instead of the biological result of having sex. Thus when she started to be sexually active, she did not think it would result in a baby, thus to her surprise she became pregnant at fifteen. This narrative demonstrates how women's knowledge was kept from the younger women until they were ready. It is also telling on how spiritually played an essential role in pregnancy even in the past and how residential schools' lack of education on adolescent bodily processes created a gap in sexual health knowledge. The teachings coming from the

women's realm were severely disrupted as the age of gaining the traditional sexual knowledge teachings were interrupted by residential school taking children away from home.

All of my participants had given birth at local hospitals surrounding their home reservations or within a metropolitan city. However, most of the younger participants were able to receive maternal care within their home communities. One elder participant had their entire maternal experiences within an urban setting, in a major city in the United States but spoken little about the maternal health services experience within an urban setting. All participants had different ways of accessing maternal care, some choosing doctors over location and others choosing location and accessibility rather than remaining with one consistent doctor. Most elders had no choice in their maternal care as there was often only one way of accessing health care, as well as many of them had not received much more than a confirmation of their pregnancy and then saw the doctor again at delivery. The elders noted a great deal of maternal health knowledge transfer from female family members and local midwives rather than accessing their knowledge from medicinal health professionals. Many women were not able to access medical care, as it was not offered to Mi'kmaw women at that period of time. Maternal health care is relatively new area in First Nations communities, and it has become increasingly important over the last twenty years as a foundation for more successful deliveries. Contemporary education models have increased maternal health knowledge resources in the communities, which were not as accessible as they are today with some older women. In addition, other factors contributing to poverty were not dealt with in a systematic way and lack of access to medical care in the community, lack of transportation, childcare, or money for other incidentals have all contributed to losses to these women in regular maternal care.

Mi'kmaw Traditional Knowledge in Maternal Health

Traditional knowledge has many ways of filtering into Mi'kmaw women's psyche. From a young age most Mi'kmaw women have experienced an informal grooming to Mi'kmaw beliefs systems and to the roles of women within the community. This can be done through role modeling, storytelling, and through having conversations

of what is expected of a strong Mi'kmaw woman during a child's transformation into adulthood. There are many ways that traditional knowledge is presented to women in regards to pregnancy.

Mi'kmaw storytelling holds that each person speaks from his or her own experience. This has its positive but also negative effects. I sought out certain respected elders to learn of traditional knowledge surrounding pregnancy and birthing, but often I found that they would only speak to their own personal knowledge rather than make broad generalizations about what others would know or do. So in the interviews, I had to change the phrasing of interviews questions from what did you hear about pregnancies from other women in your community, to "what traditional knowledge was passed down to you?" The elder participants were hesitant to become 'the expert' in maternal health and traditional knowledge. However, when I changed the paradigm to be more of a question of what was spoken of during pregnancy, I found that traditional knowledge was always present but in a subtle manner. Traditional knowledge involving pregnancy, care, well-being, delivery, etc. was not spoken about directly but in more a round about way and inferred through storytelling which led to a richer text in the form of their stories of their own or of other person's in their family experience. In other words, everyone was a great storyteller and if they had another person's story, they could tell it too. But what they would not do was to generalize any experience as 'common'.

I found that most of the younger generation was unable to distinguish what was considered traditional or modern knowledge. Some would categorize what their mothers, grandmothers or in-laws were telling them into 'fact' or 'fiction', and 'folk knowledge' categories, but regardless of their perception or value of the knowledge received, they would follow the advice given during pregnancy. One such example came with the use of relics as a way to improve or enhance their birthing experience. While some thought that these relics were solidly embedded in Mi'kmaw folk knowledge but were seen as 'superstitions' without understanding the deeper meanings and context from which these were embedded, they solely upheld these traditions without question, as they did not want to risk harm to their babies or suffer the backlash of the community's disapproval. Many of the younger participants did not believe fully in some of the Mi'kmaw legends and advice they were given, but were too afraid to trample on traditional beliefs in fear of

retribution. An overshadowing fear remained with them that if they did not follow the advice something might happen to their babies for which they would have to suffer the blame for not listening to traditional beliefs. The participants noted, for example, that elders would explain how the physical realm and the spiritual realm would intersect to create a certain outcome during pregnancy. The most common advice for all participants was for a pregnant woman not to linger in doorways as it causes the woman to be in two places at once, which results in the baby being stuck between two worlds, for example in the birth canal, because it is the doorway to life in the physical realm and to the womb in the spiritual realm. I was surprised to discover that this belief is not Mi'kmaw specific as I found similar advice to pregnant women in Long and Curry's research on Native American women and prenatal care in Oregon, USA. Their elder participants noted that "Women were cautioned to never linger in a doorway or look out a window to prevent long labors or indecisive babies" (Long and Curry⁵⁴, p. 209-210). Since the practices of Mi'kmaw women were also explained in this fashion, most women were fearful not to trample on the sacred aspects of pregnancy and followed these many guidelines laid out for them by elders. Tensions emerged, however, as the younger generation of women had much more access to maternal care information and medical support necessary than many of their elderly generation, which caused problems when one source told them one thing and another source told them the opposite. Mi'kmaw women are struggling to find a balance to reconcile both belief systems, but have mixed feelings between the traditional beliefs and western medical beliefs. They had to work with what information they had to provide the best pregnancy they could manage without stepping on any taboos of elders and taboos of Mi'kmaw culture.

While conventional education has impacted Mi'kmaw women's views on their identities and bodies, traditional knowledge has had fewer formal ways of being passed on to younger generations. There are, however, many ways of its filtering into Mi'kmaw women's psyche. From a young age most Mi'kmaw women have experienced an informal grooming into Mi'kmaw beliefs systems and into the roles of Mi'kmaq women within the community. This learning to "become a woman" has been done through role modeling, storytelling, and through having conversations of what is expected of a strong Mi'kmaw woman during a child's transformation into adulthood. There are many ways

that traditional knowledge is presented to women in regards to pregnancy. Mi'kmaw women are considered 'real' women once they have had their periods or even after giving birth, and those women who have not experienced birthing are still considered 'young' or 'little' women. Birth defines a first level of being a woman and thus creates a clear boundary into adulthood and into the prestigious women circle within the community. Motherhood is thus the cornerstone of a woman's life, which allows women to understand the importance of this cycle of life, and thereafter, they are groomed in a manner that prepares them for this transition.

Traditional knowledge on maternal health is passed down from female to female, and it is a rare occasion that a male could step into the female realm to speak about maternal health. Maternal health knowledge has been passed down from mother to daughter or grandmother to granddaughter, or aunt to niece, as these are considered the appropriate venues of the passing of traditional knowledge within the woman's realm. Most of the interactions of traditional knowledge among my participants were done by the female members of their families, in which they were offered advice on how to behave, what to eat, what to do during pregnancy, how to give birth, and how to care for their infant. This knowledge would be added to the already vast knowledge of childrearing from being groomed to care for others at an earlier age. Older girls were always in the care of others in the group, and depending on who was the oldest, each has responsibilities over others younger than them. Women were told of traditional practices that they were expected to follow such as "not making noise during delivery" so that the women would be informed and mentally prepared prior-to the event.

Since legalized midwifery in Nova Scotia has not been practiced until March 2009, there was very little discussion of Mi'kmaw women experiences with home births. In Cape Breton, hospital births were the norm from after the 1950's to present. However prior to this time, Mi'kmaw women were birthing at home or within the First Nations community, with the assistance of what can now be called a traditional midwife. Mi'kmaw midwives were not medically trained but were apprenticed from other midwives in the community. The traditional knowledge and practice of passing down knowledge and expertise among women about delivery by midwifery, however, has slowed as a result of the dominance of the medical model being promulgated as the best method of

delivery in birth. When Mi'kmaw women were finally able to use the hospitals around 1940's, most then were sent to hospitals for birthing their babies and the role of the midwife slowly disappeared. The residual effects of residential school conditioning is also to blame for the disappearance of the midwife, as most young women who would have been trained as midwives were sent away to schools for long periods of time. This has led to a gap in knowledge about midwifery in Mi'kmaw communities, which is now being brought back due to impending legalization of midwifery practices in Nova Scotia

Conflicts in Mi'kmaq and Western Values in Maternal Health

The first step I took to seeking information to answer the question about conflicts in Mi'kmaw and Western values in maternal health was to ask my participants if they had received any advice from their families, elders, or friends about pregnancy. This would allow the women to speak to what was passed down to them without putting the pressure on them to remember specific knowledge or put value on one or the other. It also allowed the advice that held the greatest value to emerge from what was embedded in the participant's consciousness. Most of the women were able to go deep into what they heard and what they were told by elders about maternal health. Some participants needed more probing about their beliefs and about 'mythology' about maternal health to uncover what they understood from their traditional beliefs and what they learned from health professionals. The stories provided the rich data that helped me to identify themes.

The major finding was that there is a constant tension between what medical health providers are telling Mi'kmaw women to do and believe during pregnancy and what their Mi'kmaw traditions and Elders are urging them to follow. Mi'kmaw women have to negotiate between two separate belief systems and be up against their cultural beliefs versus the scientific facts given outside of their cultural context. The participants were taught not to question these cultural taboos but to accept them as a part of our cultural traditions and to be proud of being who they are. On the other hand, they were also aware that the medical health professionals and their advice are backed by scientific logic, reasoning, and experience. The individual had to negotiate both sides to decide which they will follow. Thus, the participants spoke about their own inner conflicts to

avoid any conflict with health professionals and Elders. Many of the study's participants were fearful to reject any Mi'kmaw pregnancy taboos, their reasoning being that they feared retribution from mystic unseen forces, disapproval by Elders or family members, or being seen in a negative way within the community. This creates an on going tension and inner conflict within the participants own belief systems, as they must put their beliefs in a hierarchical situation of which one belief system is better than the other.

An example of this conflict is the practice of boiling bottles for babies. Biomedical knowledge would hold that it is best to boil bottles to sterilize them and rid them of any germs, thus creating less potential for illness in the child. In the Mi'kmaw belief, the woman does not boil her breast to feed her child, and those germs that are there help the child grow stronger by developing immunity early. The conflict of which practice is better is up to the mother to decide, as on one side, the child gets illness as a part of growing their immune systems and on the other, to prevent illness all together. It a difficult position for the new mother to be working within two belief systems and being unsure which to follow to create the best outcomes for their child.

Implications of the Answers to My Research Questions: Using Mi'kmaq beliefs/values to improve maternal health

In the past, Mi'kmaq women collectively held all the teachings relating to maternal health and passed them down through the generations through midwives, elders and female interactions. Birth was traditionally a time for "sharing and reinforcing the sacred knowledge of birth, and for strengthening social relationships and ties to the land"(Native Women Association of Canada⁵⁷, p. 5). Traditionally, Aboriginal midwifery, healthcare, education, and spirituality were taught orally from generation to generation. However, colonialism altered, eroded, but did not totally eradicate in many cases the sacred knowledge of homeopathic remedies, spirituality, language, culture, and worldview. These teachings have been under attack when Eurocentric values and colonization created discourses of superiority about what was valued and positive for having healthy babies, which had the effect of diminishing our midwives and traditional teachings while simultaneously elevating colonial folk knowledge and later scientific knowledge. There was a great deal of disempowerment that the participants had felt when

it came to their own medical health, from which they lost control and autonomy over their maternal health. The effects of residential schools created at least two generations that have been disconnected from midwifery practices and traditional knowledge systems. Thus contemporary health systems have developed a disconnect between a generation's knowledge about sexual and reproductive health to rely on western medicinal care. This has not been uncommon for First Nations women in Canada, as it has been discussed at length in the literature about the loss of midwifery in First Nations settings^{10, 41, 105, 107, 108}. To return Mi'kmaw values and teachings of maternal health could be both empowering and stabilizing for the future generations of Mi'kmaw mothers to learn from their elders and other older women. The combination of those knowledges would no doubt lead to a discussion of the merits of these beliefs, but it would help them to understand more fully the nature of spirituality in the growth of the human and why their ancestors held to those beliefs. The incorporation of Mi'kmaq beliefs, attitudes, and values systems would allow for the community to heal from their collective trauma, instead of enforcing Eurocentric values on a new generation. Women should prize their Mi'kmaw teachings in maternal health, instead of hiding the uses of traditional medicines and other traditional maternal health practices from their current health providers. The reclaiming of Mi'kmaq maternal teachings is one step towards regaining what has been lost due to systemic oppression of Mi'kmaw women, and to help create new avenues for new Mi'kmaw mothers to negotiate their traditional beliefs with the western medical model of health care.

Recommendations:

Mi'kmaw Knowledge Broker: I would suggest that there be within First Nations communities, a Mi'kmaw female knowledge broker available to pregnant women during and after western medical maternal health appointments. This can help Mi'kmaw women ask questions to clarify the knowledge given from health professionals. It also allows for Mi'kmaw women to have a translator on-site if they cannot understand concepts or directions given by their physicians. The knowledge broker can also provide traditional teachings to pregnant women, to help reclaim our Mi'kmaw maternal health beliefs, and allow women a safe place to discuss perceptions of 'mythology' or 'superstitions' that

circulate in Mi'kmaw communities, thus creating a better understanding of spirituality, Mi'kmaw belief systems and the expectations of motherhood.

Mi'kmaw Birthing Centers: In the research all participants had their births in a hospital, and felt disconnected from family and community. Birthing centers within First Nations settings in Canada have yielded a great deal of success in creating better outcomes in maternal health. I would recommend that Cape Breton obtain a birthing center to bring birthing back to the community and to bring back traditional midwifery. This Centre would combine the services of midwives, nurses, obstetrician/family doctors, ultra sound technicians and lactation consultants as they would work collectively to create lasting relationships with their clients, and provide cultural appropriate maternal health within the First Nations communities.

Mi'kmaw Health Education and Training: All Mi'kmaw communities need to have health care that incorporates training and implementation of cultural sensitivity, protocols, and Mi'kmaw knowledge to current maternal health programming. Also maternal health programming needs to incorporate Mi'kmaw specific maternal health folk-knowledge/beliefs into maternal health education, health promotion, and midwifery practice frameworks Mi'kmaq values systems should be considered when creating maternal health programs and policies, such as modesty in teachings about breastfeeding to improve breastfeeding rates in First Nations communities. Elders need to be consulted during programming planning, and should hold space on health boards and community health committees to ensure cultural connections and safety.

Next Steps

If I were able to continue my study in the field of maternal health, some new directions I would take would include looking at the history of traditional midwifery and the history of maternal health and how they affected each other. I would like to examine more specifically traditional knowledges as the small sample in this research has only opened a small door to that knowledge, and it would be important to explore in depth the traditional knowledge that is current in use in the Mi'kmaw community. Since my population was small, I would like to create a larger participant sample and to advance the study to look at the five Cape Breton First Nations communities individually for a

deeper analysis. I would like to have interviews with women who had experienced midwife-assisted births and to examine the decline of midwifery teachings from the past generation to present. In this future research, I would like to examine how Mi'kmaw mothers at present are accepting the traditional knowledge that is being offered, as there has been a layer of superiority of medicinal health and western values that taint many women's acceptance of their heritage. I would also expand the sample to include lesbian-bisexual Mi'kmaw women with children, as they could offer a deeper analysis of sexuality, gender, and traditional teachings that they may have experienced differently from the average heterosexual Mi'kmaw woman. I would like to include women who had experienced infertility and how they have coped with the cultural response in First Nations communities to women who cannot reproduce thus cannot live up to the 'golden' standard of womanhood through motherhood.

To the extent that this research can determine, it will yield information that will help understand who is in control of the health care of women as they go through a critical period in their lives of having babies. It will give information of how their health lay in the hands of the families, the communities, the leaders, the caretakers, and the health delivery systems. If the future is to be nurtured by the present, the issues must be analyzed now and addressed appropriately.

Strengths and Limitations

The research design, the population and the findings have several strengths and limitations. Considering first the strength, I was able to give 'voice' to a group of women who have been largely under represented in literature and in maternal health planning. The data covers a cross generational analysis over the last half century among Mi'kmaw women in Cape Breton, Nova Scotia who have experienced at least two births. This cross-generational data gives a picture of how maternal health experiences have been shaped by quality, quantity and availability of education, various kinds of knowledge, resources, and services to each generation. Each of the women's stories resonated similar themes as to how patriarchy, poverty, hegemony, and dominant Catholic values affected the consciousness and their perceptions and maternal health choices of Mi'kmaw women. Given the historical context of Mi'kmaw women's oppression, their silence, these voices

may have not been given the chance to speak out about their experiences, which would allow an outsider a view of their personal stories and cultural values.

Another strength is that this study has highlighted traditional and Indigenous knowledge teachings that have been present in literature of missionaries and in the participants' data. The teachings of becoming a woman, the folk knowledge during pregnancy, and the experiences of motherhood have highlighted how Mi'kmaw women have resisted Eurocentric and western medicinal values in favor of their traditional knowledge systems. The strength of the study is to identify how colonization, residential school and religion have affected maternal health teachings in history. It is evident that some of the Mi'kmaw knowledge systems are still very vulnerable, as we seen in the last fifty years a loss of midwifery and many of their traditional teachings. The participants were able to show their resilience against the impacts of colonization in the past half century to retain these traditional teachings that were passed through the generations. Mi'kmaw women, in general, have been able to retain traditional knowledge and teachings regarding maternity longer due to the maintenance of Mi'kmaw language, socialization in gender specific groups, and the emergence of the Mi'kmaw renaissance in their education about themselves, reclaiming, restoring and renewing their faith in their culture, in their spirituality and in themselves.

As my research population was small, it would follow that the study was not aimed at delivering broad generalizations about the entire Mi'kmaw population. Since many of the participants were living on reserve, findings are limited to analysis of on reserve women and not to what urban or non-status Mi'kmaw women may have experienced in maternal health. Since the on-reserve women have a history and context where family, language, and land connections are strong; they were able to identify with traditional knowledge and culture more so than might urban or adopted-out Mi'kmaw women who have not been able to access their roots in the Mi'kmaw community. The lack of urban Mi'kmaw women in the study also does not shed light on their access to services or feelings about their health providers. The women in the study were all from Cape Breton Island reserves, all of which are isolated from urban centers that might provide more services in other places such as 'mainland' Mi'kmaq. There was also a lack of analysis of Mi'kmaw lesbian women's maternal health, which could lead to a

great deal of future research. Since sexuality and maternity are not often linked in maternal health analysis, this may lead to future research in First Nations communities.

Conclusion

The following paragraphs will be summarizing the key teachings and lessons from my research. Mi'kmaq women, as all First Nations women when making choices on maternal health are influenced by the context in which they live, such as social economic status, poverty, education, rural/urban status, and connection to traditional knowledge sources. The participants were unable to disassociate from their insider perception of their lived experiences to note how deep an impact that systemic racism, colonization and assimilation policies have had on the changes in maternal health over the past fifty years. It demonstrated how imperative Indigenous methodology is in unearthing traditional and folk knowledges of participants and the importance of bringing culture values into maternal health.

The second discovery is that traditional knowledge in maternal health behaviors and attitudes of the participants is thriving and is resilient in First Nations communities, under the guise of “common knowledge”, “folk knowledge”, and “old wives tales”. Future researchers who look at First Nations maternal health knowledge must use a critical lens to understand the dynamic of interweaving of western medical knowledge and Mi'kmaq traditional knowledge in the decision making process during pregnancy and birth. Moreover traditional knowledge in maternal health is under attack by colonization and the medicinal authority of western beliefs, which are forcing First Nations women to walk a fine line between cultural values and medicinal health teachings. This leads to a great unspoken tension in traditional Mi'kmaq health beliefs of the participants as they feel that their cultural knowledge systems are not recognized as valued knowledge in maternal health. However, the finding of the research is that Mi'kmaw traditional knowledge is alive and well and being practiced by Mi'kmaw women in the Eskasoni First Nations community. Finally, this leads to the discovery that there needs to be a bridging of the two knowledge systems of traditional knowledge, and western medical knowledge when creating a culturally sensitive maternal health and delivery model. The assumptions of superiority in western medical systems need to be unpacked, and

Mi'kmaw people educated about those Eurocentric discourses that have led them to believe less in their own cultural knowledge.

In the journey of completing this research, I gained a great deal of knowledge of my participants, my culture, my history and my people. It was a learning experience for which I have been deeply privileged to conduct as an “insider” in many ways, being from the same culture and gender as my participants. It led to a great deal of trust that would not have been easily accessed by an outsider, as relationships were built and maintained throughout the study, and will continue throughout my life. These women acted as teachers to me, ‘the researcher’, as would have been traditionally done with one who is childless, and speaking about pregnancy and birth would be a part of social grooming to one becoming a woman. Having family and land connections in the community that I conducted the research allowed me a great deal of freedom in accessing participants, who were very timid to speak about such a personal and private matter of maternal health. I acknowledged this privilege as a means to help those who may want to conduct research in First Nations communities in maternal health to understand that First Nations lived experiences have been deeply constrained by their social-political context and their cultural history.

EPILOGUE

FINAL THOUGHTS

The epilogue was created to insert valuable knowledge about the research process of working within a First Nations Community, which did not quite fit into the thesis. It is important to me to share my lessons and teachings to help other potential students working in a similar field to understand Indigenous research processes and methodologies.

My reflections on the research processes

Although I enjoyed my research process, I often found myself lost between two worlds, the one I was raised in with traditional practices build around relationships and the academic world that was being imposed on me as a student in a westernized university. I had to find my own voice and methodology to conquer each world until they complemented each other in my mind. I found the beginning process of research difficult, as community members were hesitant towards the research but offering me rich stories of their personal experiences. It took a great deal of relationship building to gain the trust of community members that my research was not the typical research methods that have wronged First Nations peoples in the past.

Once I gathered enough friends, family and community members to appreciate my somewhat unique research approach, it was easier to find participants. However, not every participant wanted to be apart of a Participant Action Research approach. . Often they would tell me that they trusted me with the knowledge, and trusted what I would come up with the right findings. This had led me to feel a great deal of pressure and worry that I would fail my participants. Fear of failure made me negotiate my own beliefs, values and attitudes cautiously and often led me to question myself. Who was I to question the medical western model of care or the traditional models of care? From walking between these two worlds, it often took me a great amount of effort to decide what to write about and what I should share with this vast knowledge that was given to me.

These struggles were all addressed during the methodology. I found myself often wondering if the struggle was worth the outcome, as there was no light for change during the research and analysis process. Then there was a light of hope, when maternal health professionals were seeking my advice on how to approach Mi'kmaw women to better their health care. From these experiences and presentations, my name came up as a potential employee at the Eskasoni Community Health Center. I received a job interview for a new position, Midwifery Research Coordinator. Once the interview process was over, I was offered a full-time term position to conduct research about traditional midwifery practices and maternal health over a twenty-month period. I was negotiating the medicinal world knowledge and trying to find my own voice to represent the Mi'kmaw women of the community, so that they could get the best maternal health care possible. I worked on this project for nearly two years to produce a midwifery model of health care for a First Nations community setting. This allowed for the traditional beliefs, practices and behaviors to be reflected in their maternal health.

The research process has helped me gain the experiences of doing research in a First Nations Community. Lived experiences and the learning from this thesis project has been used to create better research practices within First Nations Communities of Cape Breton. From learning how to negotiate interview times, how to follow up with participants and to how to approach elders, all the learning have been applied to the lived experiences of the researcher. The learning process has seemed to have taken a great deal of time and effort on the researcher's part, but it only lead to greater understanding of Mi'kmaw women's health and maternal health history within the First Nations communities. The community has benefited in more ways than one, to have the researcher continue the work started within this thesis.

The research process was often a learning process, filled with requirements and regulations that I often did not fully understand. The technical language was something that had to be learned on my part. I felt that there was little guidance on what a thesis should look like when approached from an Indigenous perspective or whether I was adequately prepared for the enormous undertaking. Since I created my own methodology and research topic, which had very little literature to work from, I found myself having to 'make ground on the back of a turtle'. The guidance of supervisors and other Indigenous

academics fueled my confidence that the methodology and methods of the thesis were validated and traditional in nature. To me, the method I chose was one that felt comfortable within a First Nations context and that felt natural and organic to gaining knowledge. Using the narrative inquiry is another method of storytelling and allowing the participant to tell their stories without the strict guidelines of questions and answer interviews, but it also allowed for traditional oral histories to be told. I felt that the research methodology was authentic to how Indigenous peoples collected and obtained data without imposing Western values on their research.

The medicine wheel has been a great research tool for maternal health as it is easily categorized into each part of the wheel, spiritual, mental, physical and emotional. This tool had greatly helped me think of each experience and story in a certain context without feeling restricted by themes or rigid categories. I felt the medicine wheel model worked well with my outcomes of hearing women's voices and experiences. It allowed for room for stories of grief, of pain, of joy, and of all emotions that are tied within pregnancy and birthing stories. Each woman spoke about her pregnancy as a precious time within their lives where life-changing events occurred. To use the medicine wheel allows for those women's stories to be understood, in a Indigenous manner and to be analysis in a way that made common sense to the researcher.

Barriers in the Research Process

During the interview process, the main barriers were with obtaining participants and teaching them about the complexities of research processes, including the informed consent. Most women were unaware of the research process and once they knew I was on this search, they often were willing to tell their pregnancy stories spontaneously during social events within the community, which reverberated in the room with other women and they would all have to say something about their experiences. My problem was I did not have an informed consent forms, tape recorder, notes, etc. so much knowledge was lost. . With the participants that were recorded, the research process took much relationship building and trust building with the researcher and the participant. The researcher had to call to remind the participants of the interview, numerous times as in a

fluid community; appointment times are not seen as rigid or inflexible. There were some cases when I created more than one time for an interview, as many of the interviewees would not show up at the appointed times or they forgot completely about the interview. One participant was dealing with her children having lice, during our interview, and thus the interview started 2 hours later than planned. These incidences are all a part of living within a First Nations community, for as crises arise, everything else can go to the side. The barrier of keeping and planning interviews was a challenge, but with being flexible, forgiving, and honest with participants, it allowed for greater relationship building that created for a better research atmosphere during interviews.

Another barrier in most interviews was interview space and confidentiality. Since most members of the community knew of my thesis project, most assumed if I was present in a home, that I was there doing interviews. This led to a creative approach to keeping confidentiality, the researcher who previously sold AVON products, used AVON books and products to enter participant's homes without suspicion of the community. The researcher would take AVON books (which often had phone numbers/emails of the AVON representative) to the participant's homes, in case anyone questioned the researcher's presence in the home, therefore creating outward confidentiality in a tight knit community of people who often recognize owners of vehicles. Since most participants were mothers, another difficulty was to get a quiet, confidential space to conduct an hour interview. Many of the interviews were conducted in my home space around a kitchen table, when the mothers could arrange for childcare. Other times, children were in and out of the room where the interview took place. There were occasions when phone calls, visitors, and family members interrupted interviews. Patience was a virtue during these types of interviews. At times, a hour interview could take up to three hours of the researchers time, as it allowed for time to small talk and get comfortable, the interview process, a few interruptions, and small talk/tea after the interview was conducted. The barrier was overcome by being flexible to change, and able to find creative ways to maintain confidentiality.

APPENDIX A

MI'KMAQ ETHICS APPROVAL EMAIL

March 21, 2007

**Mariah Battiste
Department of Community Health and Epidemiology
University of Saskatchewan
Health Sciences building, 107 Wiggins Road
Saskatoon, SK S7N 5E5**

Dear Mariah:

I wish to inform you that the Mi'kmaw Ethics Watch committee has reviewed and approved your ethics application, "Nurturing the Future: Exploring Maternal Health Knowledge, Attitudes and Behaviors among Mi'kmaq Women.

This enables you to move forward with your project.

We would be pleased or appreciative if and when the study is completed that it be provided so as to allow our students to build further academic foundations and a better understanding of Indigenous knowledge.

If you have any questions concerning same, please do not hesitate to contact us.

Sincerely,

**Lindsay Marshall
Associate Dean
Mi'kmaq College Institute**

APPENDIX B

UNIVERSITY OF SASKATCHEWAN ETHICS APPROVAL



UNIVERSITY OF
SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

Certificate of Approval

PRINCIPAL INVESTIGATOR
Janet Smylie

DEPARTMENT
Community Health and Epidemiology

BEH#
07-40

INSTITUTION(S) WHERE RESEARCH WILL BE CONDUCTED
University of Saskatchewan
Saskatoon SK

SUB-INVESTIGATOR(S)
Sylvia Abonyi

STUDENT RESEARCHERS
Mariah Battiste

SPONSOR

TITLE
Nurturing the Future: Exploring Maternal Health Knowledge, Attitudes and Behaviour Among Mi'kmaq Women

ORIGINAL REVIEW DATE
27-Feb-2007

APPROVAL ON
02-Apr-2007

APPROVAL OF:
Application
Recruitment Materials
Consent Forms
Questionnaires

EXPIRY DATE
31-Mar-2009

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: http://www.usask.ca/research/ethics_review/

John Rigby, Chair
University of Saskatchewan
Behavioural Research Ethics Board

Please send all correspondence to:

Ethics Office
University of Saskatchewan
Room 302 Kirk Hall, 117 Science Place
Saskatoon SK S7N 5C8
Telephone: (306) 966-2975 Fax: (306) 966-2069

APPENDIX C
RECRUITMENT POSTER

Attention: Women with Children

Are you interested in taking part in a study exploring

Maternal Health in Mi'kmaq Women?

I am a Mi'kmaq woman conducting a research study for my master's degree in Community Health and Epidemiology at University of Saskatchewan, and I am looking for women to participate in this study to understand women's feelings, thoughts and knowledge about their experiences during and after pregnancies.

- ✓ **Are you a Mi'kmaq woman?**
- ✓ **Are you living on reserve?**
- ✓ **Are you between 20 and 65 years old?**
- ✓ **Have you had a pregnancy while living on reserve?**

If you answered, “yes” to all of these questions, and you are interested and willing to participate in a 1-2 hour interview process discussing your pregnancy and experiences with maternal health care services:

Please contact Mariah Battiste, for more information.

Contact: Mariah Battiste

An honorarium will be provided for your time and participation.

This study has been approved by the Mi'kmaq Ethics Watch & the University of Saskatchewan's Health Sciences Human Research Ethics Board.

APPENDIX D

CONSENT FORM- INDIVIDUAL INTERVIEWS



CONSENT FORM: PARTICIPANTS

You are invited to participate in a study entitled “Nurturing the Future: Exploring Maternal Health Knowledge, Attitudes and Behaviours Among Mi’kmaq Women”. Please read this form carefully, and feel free to ask questions you might have.

Researcher: *Mariah Battiste, BA (Bachelor of Arts Honours in Women Studies),*
(Community Health and Epidemiology Masters Candidate)
Department of Community Health and Epidemiology
U of S, Health Sciences Building, 107 Wiggins Road
Saskatoon, SK S7N 5E5

Email: [REDACTED]

The Indigenous Peoples’ Health Research Centre-funded Master’s project, “*Nurturing the Future: Exploring Maternal Health Knowledge, Attitudes and Behaviours Among Mi’kmaq Women*” will seek to enhance Aboriginal knowledge on the topic of maternal and prenatal health within Mi’kmaq communities. The purpose is to increase the knowledge and understanding of how Mi’kmaq women use traditional maternal health knowledge in health promotion and program planning. Another purpose is to describe culturally significant and relevant concepts of fetal / Infant health.

Up to 20 female participants from Mi’kmaq reserves in Cape Breton will be interviewed. The interviews will be open-ended questions that will occur in participant’s homes or at another location of the participant’s choice. A cultural or Mi’kmaq language interpreter will be used, if required. The interviews will be recorded and transcribed. It is anticipated that each interview will take up to 2 hours. Follow up interviews will be conducted to provide the participant to review their own transcribed transcripts and to give the researcher a chance to explore and clarify their stories and any new emerging themes. The oral histories will be reported back to the participants privately before any material is presented or reported. Because of the size of communities involved in the study, there is a chance that the information the participant provides will identify them to others in the community. However, the participants will be given a chance to revise (add, change or delete) their transcripts before any publications to ensure their anonymity.

This study may be seen as a participatory research with Aboriginal communities, and may hold the potential to be helpful in public health policies and prenatal health programming. The knowledge produced in this study **may and may not** help to benefit directly the health policies in your community. There are minimal risks to participating in the *Nurturing the Future* study beyond disruption in daily routine or emotional responses participants might have to sharing information regarding their maternal experiences.

Copies of transcripts and videotape segments will be given to the participants for personal safekeeping and use. If the community involved in the study has the capacity to hold their own research records, it is possible copies may be stored within communities. The primary researcher, Mariah Battiste, will also have control of interview materials and copies for her confidential records. Mariah Battiste will use the information gathered to write her Master's thesis in Community Health and Epidemiology at the University of Saskatchewan. The supervisors of Mariah Battiste are Dr. Janet Smylie and Dr. Sylvia Abonyi who may also have access to copies of research records to help provide advice and to validate the researcher's analysis.

I, _____, from _____ have read the information and I agree to participate in the *Nurturing the Future: Exploring Maternal Health Knowledge, Attitudes and Behaviours Among Mi'kmaq Women* study prepared by Mariah Battiste. I understand the purpose of the project as stated and understand the following:

- I understand that my participation in *Nurturing the Future: Exploring Maternal Health Knowledge, Attitudes and Behaviours* study will consist of 1-2 interviews at my home or any other location of my choice for approximately 2 hours each.
- I understand that there is minimal risk to my wellbeing through my participation, except for the disruption to my daily routine.
- The interviews may be recorded and transcribed.
- The information that I share with the researcher will remain anonymous in the final written thesis and I have the right to edit my own transcripts.
- Unedited audiotapes, videotapes and transcripts will be held in confidential locked cabinets of the primary researcher and in password guarded computers. The information will be kept for a period of five years where it will be destroyed by the researcher.
- The final edits and transcripts will be available for my review and feedback prior to dissemination. A final copy of the thesis will be given to me upon its completion.
- I have the right to choose an alias to be used in to refer myself in the final document.
- I have the right to withdraw from the study at any time and any record of my information will be destroyed and deleted. This will not affect my relationship with the primary researcher, nor with the University of Saskatchewan and their services.
- There are two copies of this consent form, one for myself and one for the primary researcher records.

I understand that if I have any concerns or questions at any time concerning this study, I can contact the primary researcher, Mariah Battiste at the numbers provided.

University of Saskatchewan Behavioural Sciences Research Ethics Board approved this study on _____, 2007. Also Mi'kmaq Ethics Watch approved this study. Any questions regarding your rights as a participant may be addressed to the Behavioural Research Ethics Officer of the University of Saskatchewan, Randee Melancon, randee.melancon@usask.ca (306-966-2084)

Participant

Date

Researcher (Mariah Battiste)

Date

APPENDIX E

TRANSCRIPT RELEASE FORM



Transcript Release Form

PART A:

I, _____, have reviewed the complete transcript of my personal interview and/or of my personal participation in a focus group, in the study: *Nurturing the Future: Exploring Maternal Health Knowledge, Attitudes and Behaviour Among Mi'kmaq Women*. I have been provided with the opportunity to add, alter, and delete information from the transcript/videotape as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview and/or in the focus group I participated in with Mariah Battiste. I hereby authorize the release of this transcript to Mariah Battiste to be used in the manner described in the consent form. I have received a copy of this Data/Transcript Release Form for my own records.

Participant

Date

Researcher (Mariah Battiste)

Date

PART B (optional):

I am also aware that my community may want to have these transcripts stored in the community for future reference. I hereby _____ ***agree*** or _____ ***do not agree*** to have my depersonalized transcripts, that I have approved to be used by community health workers.

Participant

Date

Researcher (Mariah Battiste)

Date

APPENDIX F

FOCUS GROUP CONSENT FORM



CONSENT FORM: Focus Group Participant

You are invited to participate in a study entitled nurturing the Future: Exploring Maternal Health Knowledge, Attitudes and Behaviours Among Mi'kmaq Women. Please read this form carefully, and feel free to ask questions you might have.

Researcher: *Mariah Battiste, BA (Bachelor of Arts Honours in Women Studies),*

(Community Health and Epidemiology Masters Candidate)
Department of Community Health and Epidemiology
University of Saskatchewan
Health Sciences Building, 107 Wiggins Road
Saskatoon, SK S7N 5E5

Email: mariah.battiste@usask.ca

Home Phone: [REDACTED]

Home Address: [REDACTED]

The Indigenous Peoples' Health Research Centre-funded Master's project, "*Nurturing the Future: Exploring Maternal Health Knowledge, Attitudes and Behaviours Among Mi'kmaq Women*" will try to enhance Aboriginal knowledge on the topic of maternal and prenatal health within Mi'kmaq communities. The hope is to increase the use of traditional maternal health knowledge in health promotion and program planning. Also the hope is to describe culturally significant and relevant concepts of fetal/infant health of the Mi'kmaq people. Up to 20 female participants from Mi'kmaq reserves in Cape Breton will be interviewed. In addition to individual interviews there will be two focus groups to discuss common themes in birthing stories and prenatal care. The focus groups will have open-ended questions about their personal experience during pregnancy. A cultural or Mi'kmaq language interpreter will be used if required. The focus group discussion will be recorded and transcribed. It is anticipated that each focus group will take up to 2 hours and will be taken place in a location determined by the research. Follow up interviews may be conducted to provide clarity and to give the researcher a chance to explore any new emerging themes that arrive from the focus group findings. The oral histories/stories will be reported back to the participant privately before any materials is presented or reported.

Due of the size of communities involved in the study, there is a chance that the information the participants share will identify them to others in the community. Participants must be aware that the risk of disclosure is higher in focus groups than in personalized interviews. The researcher will ensure anonymity or confidentiality throughout the research, and take special care during the written phase to ensure your identity is concealed. However during a focus group, a participant must also understand confidentiality must be upheld by the other participants involved in the focus group. The saying “what is said in these room, stays in this room” will be stated early on to try to make participants understand that sharing private information during the focus group should be kept between the members of the focus group. As you are giving your trust to the others, they are also entrusting in you, to keep comments private after the focus group is over.

This study may be seen as a participatory research with Aboriginal communities, and may hold the potential to be helpful in public health policies and prenatal programming. The knowledge produced in this study **may and may not** help to benefit directly the health policies in your community. There are minimal risks to participating in the *Nurturing the Future* study beyond disruption in daily routine or emotional responses participants might have to sharing information regarding their maternal experiences.

Copies of transcripts and videotape segments will be given to the participants for personal safekeeping and use. If the community involved in the study has the capacity to hold their own research records, it is possible copies may be stored within communities. The primary researcher, Mariah Battiste, will also have control of interview materials and copies for her confidential records. Mariah Battiste will use the information gathered to prepare for her Master’s thesis in Community Health and Epidemiology at the University of Saskatchewan. The supervisors of Mariah Battiste, Dr. Janet Smylie and Dr. Sylvia Abonyi may also have access to copies of research records to help provide and validate analysis.

I, _____, from _____ have read the information and I agree to participate in the focus group for the *Nurturing the Future: Exploring Maternal Health Knowledge, Attitudes and Behaviours Among Mi’kmaq Women* study prepared by Mariah Battiste. I understand the purpose of the project as stated and understand the following:

- I understand that my participation in *Nurturing the Future: Exploring Maternal Health Knowledge, Attitudes and Behaviours* study will consist of 1-2 hour focus group with other women from my community.
- I understand that **mutual confidentiality among the participants must follow to ensure confidentiality of all participants.**
- I understand that there is minimal risk to my wellbeing through my participation, except for the disruption to my daily routine.
- The focus group will be recorded and transcribed by Mariah Battiste.
- The information that I share with the researcher will remain anonymous in the final written thesis and I have the right to edit out anything in my own transcripts.

- Unedited audiotapes, videotapes and transcripts will be held in confidential locked cabinets of the primary researcher and in password guarded computers. The information will be kept for a period of five years where it will be destroyed by the researcher.
- The final edits and transcripts will be available for my review and feedback prior to dissemination. A final copy of the thesis will be given to me upon its completion.
- I have the right to choose an alias to be used in to refer myself in the final document.
- I have the right to withdraw from the study at any time and any record of my information will be destroyed and deleted. This will not affect my relationship with the primary researcher, nor with the University of Saskatchewan and their services.
- There are two copies of this consent form, one for myself and one for the primary researcher's records.

If you have any concerns or questions at any time concerning this study, please feel free to ask at any point: you are also free to contact the primary researcher, Mariah Battiste at the numbers provided. University of Saskatchewan Behavioural Sciences Research Ethics Board approved this study on _____, 2007. Mi'kmaq Ethics Watch approved this study on _____, 2007. Any questions regarding your rights as a participant may be addressed to the Behavioural Research Ethics Officer of the University of Saskatchewan, Randee Melancon, randee.melancon@usask.ca (306-966-2084)

Participant

Date

Researcher (Mariah Battiste)

Date

APPENDIX G

QUESTIONS USED DURING INTERVIEWS

Background Information:

Tell me your story of your 1st pregnancy and what you remember of the medical care that you received. Do you remember any other pregnancies that you wish to share

When did you become pregnant for the 1st time?

- ☐ How old were you at that time?
- ☐ Where were you living at that time?
- ☐ What type of relationship were you in? Common-law, married, single...
- ☐ How were you able to support yourself? Welfare, job, school check.

Did you have any medical problems before becoming pregnant? What was your health status before getting pregnant?

What would you say was the health status of your 1st, 2nd, etc. pregnancy?

How did you find out that you were pregnant?

How did you tell others (significant other, parents) that you were pregnant?

What advice about pregnancy was given at that point of time?

Traditional Knowledge and Knowledge Transfer:

What kinds of advice did you hear from ____ about pregnancies and taking care of babies?

Are there any Mi'kmaq traditional stories that you are aware of, that surround women and pregnancies?

Did you use any traditional medicines to soothe pregnancy related illness?

What superstitions or folklore did you participate in during your pregnancies?

What types of Traditional Taboos regarding pregnancies are you aware of?

What other types of societal (health) taboos (smoking, etc.) did you participate in?

Prenatal Care:

What kinds of post-natal care did you receive and how did it help your pregnancy?

When did you get your first prenatal check-up? Ultrasound? Pap test? STI test?

Did you receive any information on post-partum depression or on infant hygiene?

What was your experience with prenatal care (both traditionally and medically)?

Did you experience any problems with ____ during your pregnancies?

- ☐ Racism & Colonization

- ☐ Access to medical resources

Were there any problems during your pregnancies that could be related medical problems?

Where did you give birth? Who was there? What could have been done to make your birthing experience more positive?

- ☐ How did the hospital staff treat you?
- ☐ Did you experience any mental discomfort in dealing with hospital staff?

What changes would you suggest to make your pregnancy more positive experience? Policy changes? Would more Aboriginal nurses and doctors improve your comfort level?

In your own words, tell me of any negative or positive experiences you when through during your pregnancies and post-natal care?

APPENDIX H

MI'KMAQ TRADITIONAL FOLK KNOWLEDGE LIST

Mi'kmaw Folk Knowledge: Gathered for Nurturing the Future Thesis

Written by Mariah Battiste

Food

1. Avoid Salt –causes swelling
2. Cranberry Juice can take away infections from a bladder infection
3. Don't drink pop
4. Don't have caffeine
5. Don't eat apple, chocolate, turnips, cucumber while breastfeeding cause it causes discomfort
6. Don't eat apples, they make you gassy
7. Don't eat chocolate cause it makes the baby agitated
8. Don't eat peanut butter while pregnant
9. Eat good food
10. Eat less junk food
11. Eat what you want
12. Give into your cravings
13. Eat lots of corn and you will get lots of milk
14. Don't eat shellfish
15. Eat Liver so you won't be low on iron, and to prevent headaches
16. Take maternal vitamins

Clothing

17. Always wear socks
18. Don't go barefoot
19. Don't let your feet be cold
20. Don't dress provocatively
21. Don't wear tights, spandex, tight clothes or any type of tight clothing cause you may be choking the baby/circulation/placenta

Behavior

22. The Father couldn't go hunting
23. The father couldn't kill or slaughter animals for food

24. The father couldn't use a gun – not even to bring in the year
25. Its bad for partner to take a life when you are expecting as it will come back to you in the future (example of a man hunting during pregnancy and child died as a preteen and people contribute it to his disrespect for life during the pregnancy)
26. Don't agitate any human or animal blood, it may start your blood flowing Don't clean fish
27. Don't touch animal blood
28. Don't take care of food that involves blood, that draws blood like skinning rabbits
29. Don't witness anything to do with blood such as skinning game (after 3 months)
30. Don't get a pregnancy portrait as it bad luck, if something ever happen to the baby, its kind of like stealing the babies soul
31. Don't allow people to take your picture
32. Don't be a cranky pregnant woman
33. Don't be mean to kids or other people, watch what you do
34. Avoid Sex
35. Don't buy anything before hand, don't by anything at all for your unborn child cause it will bring bad luck
36. No baby showers before the baby is born
37. You can put stuff on lay-way but don't bring it into the home until after the baby is born
38. No getting the room / nursery ready
39. Don't cut your hair or perm it or color it
40. Don't drive yourself around too much in last trimester
41. Don't go bike riding
42. Don't go on long trips
43. Don't go sledding
44. Don't go swimming
45. If you did go swimming don't dive under the water cause you take away oxygen from the baby and you may get a stillborn
46. Don't go into a hot tub cause you will give your baby a fever inside the womb
47. Don't lift up kids and stuff
48. Don't Lift heavy things
49. Don't lift your arms above your head or the movement will stretch the cord in your uterus and it could get tangled up.
50. Don't carry grocery or even 2lt pop
51. Don't look out the window, cause you will have a hard labor
52. Don't be looking out to wait for someone,
53. Don't put your head up against the glass to look out
54. Don't stick your head out of windows or doors
55. When you open a door you go all the way out
56. Don't make fun of the way people look or your baby will take on those qualities
57. Your spouse is not allowed to make fun of the way someone looks

- 58.**Don't even think anything bad cause it can be like Karma and come back to you
- 59.**Every thought and every emotion you go through your child goes through too, so you have to be careful of what you think of
- 60.**The baby will feel everything you feel
- 61.**Don't teach your baby negative emotions, cause babies aren't born with instinctive emotions like fear, hate and anger.
- 62.**Don't look at violence
- 63.**Don't raise your arms or you might unattached the baby
- 64.**Don't hang clothes on clothes lines (after 6 months)
- 65.**Don't wash walls
- 66.**Don't reach high places or lift everything over your head
- 67.**Don't make noise during labor, just pray
- 68.**Don't stand at doorways or your baby soul will be confused
- 69.**No horsing around
- 70.**No men in the delivery room, exemptions for doctors/nurses.
- 71.**No smoking
- 72.**No stress
- 73.**You should have Natural birth
- 74.**Don't get epidurals cause they makes you lazy during labor
- 75.**You should wear a knotted necklace with a St. Anne Medallion, a St. Anne cloth from 'the island' so that St. Anne will watch over you.
- 76.**Don't talk nasty or swear or stuff like that
- 77.**You shouldn't get scared
- 78.**Don't look at movies that might scare you or shows violence
- 79.**Don't look at people fighting or even dogs fighting
- 80.**Younger children can predict the gender of the child and if there are having twins
- 81.**Its bad luck to find out the sex of your child
- 82.**Never disrupt the spirit world for personal gratification
- 83.**If you witness a multiple birthing of animals or anything like that, then you will have a multiple birth
- 84.**Don't treat animals poorly, or kick them.
- 85.**If you have a lot of heartburn your baby will have lots of hair
- 86.**If you put an needle above your wrist, the direction it takes can dictate the gender of the child
- 87.**Talk to your fetus as soon as you find out your pregnant
- 88.**Tell the fetus where your going, what your doing, and when your leaving so the spirit will follow you
- 89.**Speak Mi'kmaw to your fetus so that s/he will know her language
- 90.**Don't use goo-goo gaa-gaa talk cause your baby understand what your saying (on a spiritual level)
- 91.**When you clean the table you don't stretch your arm out to wipe, but to walk around table and clean the table in sections, if you don't do that you will have a hard time

- with your baby, or you will be in labor for a long time cause your baby will be sticking out and wont come all the way out
- 92.** When you get up from sleep don't turn while laying down, get up and move your body towards the direction you want to sleep and then reposition yourself, if you don't settle your body then you upset your baby and the baby could strangle themselves with the cord
 - 93.** Treat yourself good
 - 94.** What happens to you during pregnancy can show up on your baby, ex. EM mother fell on her bum and got a bruise and then her child was born with a blue bum.
 - 95.** If you don't take care of your bladder infections you can start premature labor
 - 96.** Your not suppose to have peppermint* (traditional medicine of using peppermint extract with sugar and water for colds and fevers)
 - 97.** Remember these myths, cause they are never told to you until your pregnant, and there will be a long list of do and don't that you have to learn
 - 98.** Scrubbing the Kitchen Floor can cause you to go into labor due to the shaking of the stomach.
 - 99.** How your temperament is during pregnancy is how your baby's temperament will be

Post Pregnancy

- 100.** Rub alcohol on the belly button of the baby until it falls off
- 101.** Save the Umbilical cord
- 102.** When you cut the umbilical cord, cut it about the length of your hand so that the baby can still get nutrition's from the umbilical cord, the baby will be healthy longer if you do this.
- 103.** If you bury the cord around your home, the child will come back home, or be attracted to the place their life line is buried
- 104.** If you throw the umbilical cord in the garbage your baby will be a garbage picker, if you keep it the belly button in a container your baby will be a junk collector, if you put it in the toilet the baby will be playing in the toilet
- 105.** Bury the Baby's umbilical cord
- 106.** People hang around where their life line /cord was buried
- 107.** Never look at your baby from a bottle
- 108.** Let babies cry, they need 15 minutes a day of crying to exercise their lungs
- 109.** Don't Leave your baby alone too long
- 110.** Don't let your breast get cold, or your breast (your milk) will freeze
- 111.** After you have your baby you stay in bed for 2 weeks If you don't- you will have a hard time with your stomach when your older
- 112.** Don't do "Men" Jobs
- 113.** Don't do dishes, mopping the floor, don't even pick up a broom, so you can take care of yourself after giving birth
- 114.** Don't do Manual Labor

- 115.** Don't do touch anything (cleaning wise) after giving birth for two months
- 116.** Don't clean, Don't go up the stairs, Don't lift anything for 2 weeks after birth
- 117.** Don't let other children to trample on the baby crib, cause the spirit may linger behind or wander away from the baby and the children are trampling on the spirit of the child
- 118.** Don't boil the babies bottles, cause you kill his immunities and wont have a decent life cause they would get sick more
- 119.** If the corners of the nose around a infant is blue'ish then the baby has gas
- 120.** For gas put them in a basinet with something hard underneath, and wrap the baby in a blanket around the board, with hands inside so the pressure would go down on the stomach and lay them down on the stomach so that the gas would come out.
- 121.** Put Cabbage on your breast to stop milk production
- 122.** When the baby turns 3 months you chew their food and introduce solid food
- 123.** Sleep with your baby, cause the rhythm of your breathing will remind them to also breathe /so they wont forget to breathe
- 124.** Don't let the baby sleep in your bed, cause you may roll over on it and kill them
- 125.** How you sleep patterns are during pregnancy will be how your baby will sleep.

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